

VR A15 (4)
20 M 1/66

Item O Film G385 2/15/67 mh

CERTIFICATE OF DEATH

00837

00837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Adams</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1913</u> 12-20-12
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>		9b. AGE (In years last birthday) <u>53</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Patron + Sons</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mont. Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George A. Adams</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza Jackson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>7-12-12-12</u>		17. INFORMANT <u>Wife - Mary - Same</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u> DUE TO <u>Metastatic Carcinoma</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Carcinoma, floor of mouth</u> (c) <u>"</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 h</u> <u>3 1/2 yrs</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/9/66</u> , 19 <u>66</u> , to <u>1/6/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/6/67</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Soderick Johnson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. Soderick Johnson</u>		22d. ADDRESS <u>10400 Connecticut Ave, Kensington Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>buried</u>		23b. DATE THEREOF <u>1-9-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandy Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert C. Anderson</u> ADDRESS <u>Lockville Md.</u>		25. REC'D BY REGISTRAR DATE <u>JAN 10 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		25b. REGISTRAR'S SIGNATURE	

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Cleared with Medical Examiner Jan. 16, 1967

(Dr. Beldon Reap)
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 VR A15 (4)
 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00838					00838				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b Washington Sanitarium d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9310 Parkhill Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Edward Middle K. Last ALLEN					4. DATE OF DEATH Month Jan. Day 16, Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1892		9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edward Allen					14. MOTHER'S MAIDEN NAME Annie C. Kemp				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Neice Mrs. Edna Thomas Address 612 Norwood Dr. Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris DUE TO (b) Coronary Insufficiency DUE TO (c) Afterioeclerotic Heart Disease CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH sudden 11 years 11 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 19 , 19 57 , to Jan. 16 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 5 , 19 67 , and that death occurred at 8:42 PM , from the causes and on the date stated above.									
22a. SIGNATURE Robert G. Angle						22b. DATE SIGNED Jan. 16, 1967		22c. PHYSICIAN'S NAME (Type) Robert C. Angle, M.D.	
22d. ADDRESS 5009 Del Ray Avenue, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment			23b. DATE THEREOF 1-19-67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincon Mausoleum		23d. LOCATION (City, town or county) (State) Prince George County, Md.		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR JAN 20 1967			
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1967, p. 11, 106 and 107, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 92

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. Page 1 of this certificate is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00839						00839					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission)					
a. COUNTY <u>Montgomery</u>						STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<u>SILVER SPRING</u>						<u>Laurel</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS					
<u>1 YR 3 MOS 18 DAYS</u>						<u>319 TALBOTT AVE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<u>Fairland Nursing Home</u>											
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
<u>CLAUDE ELMO AMERICA</u>						<u>January 23 1967</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
<u>M</u>		<u>W</u>				<u>July 13 1888</u>		<u>78</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
<u>guard</u>				<u>US Army Major</u>				<u>Washington, D.C.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
<u>George America</u>				<u>Frances Virginia Scott</u>				<u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
<u>yes</u>				<u>579-12-3575</u>				<u>Dora J. America Laurel Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)						<u>Viral Pneumonia</u>					
334X						<u>1 wk</u>					
DUE TO											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						(b) <u>Cerebral Arteriosclerosis</u>					
						<u>2 yrs</u>					
						(c) <u>Generalized Arteriosclerosis</u>					
						<u>20 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY						20d. INJURY OCCURRED					
Hour a.m. p.m. 19						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/67</u> , 19 <u>46</u> to <u>1/23</u> , 19 <u>67</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>1/22</u> , 19 <u>67</u> , and that death occurred at <u>2A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
<u>J M Warren</u>						<u>1/27/67</u>					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
<u>J M Warren</u>						<u>Laurel Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)	
<u>Burial</u>				<u>1-25-67</u>		<u>Trinity Hill Cemetery</u>				<u>Laurel Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REG'D BY REGISTRAR					
<u>De Witt Donaldson</u>						<u>JAN 31 1967</u>					
ADDRESS						25b. REGISTRAR'S SIGNATURE					
<u>Laurel Md</u>						<u>Charles Judge</u>					

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CERTIFICATE OF DEATH

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00840

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb 3 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1015 Woodside Pkwy. e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) RAYMOND EDWARD ASHDOWN SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasurer 10b. KIND OF BUSINESS OR INDUSTRY Dist. Theater Corp. 11. BIRTHPLACE (County & State, or foreign country) District of Columbia 12. CITIZEN OF WHAT COUNTRY? U. S. A.		4. DATE OF DEATH Jan. 21 19 67 5. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min. 8. DATE OF BIRTH 5/16/06 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME William L. Ashdown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 578-019457 17. INFORMANT Mrs. Katherine Ashdown		14. MOTHER'S MAIDEN NAME India May Bidgood Address 1015 Woodside Pkwy. Sil. Sp., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation - Shock Capitate AV block. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Posterior Myocardial Infarct. DUE TO (c) ARTERIOSCLEROSIS, THROMBI.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 to 25 min. Over 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 65 , to Jan 21 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 21 , 19 67 , and that death occurred at 7:55 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Hugo G. Graziani, M.D. 22c. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI, M.D.		22b. DATE SIGNED Jan 21, 1967 22d. ADDRESS 10101 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 25, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Swittand, Maryland	
24. FUNERAL DIRECTOR Glen Carter, 8434 Georgia Avenue, Silver Spring, Md.		25a. REC'D BY REGISTRAR JAN 26 1967 25b. REGISTRAR'S SIGNATURE Charles Juerg	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

00841

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 1840 Mintwood Place, Dist. of C. b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marylander Home of Rest		d. STREET ADDRESS 1840 Mintwood Place, N.W.	
3. NAME OF DECEASED (Type or print) First Mattie Middle G. Last Aub		4. DATE OF DEATH Month Jan Day 2 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 19 Days 66 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-03-2258	
17. INFORMANT Miss Maryland Aub, 76 Hutchinson Blvd. Scarsdale, N.Y.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 30 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-2 , 1967, to 1-2 , 1967, that (I) (was) last saw the deceased alive on 1-2 , 1967, and that death occurred at 2:30 PM , from causes and on the date stated above.			
22a. SIGNATURE W. J. Had		22b. DATE SIGNED 1-2-67	
22c. PHYSICIAN'S NAME (Type) W. J. Had		22d. ADDRESS 615 WEST MONTGOMERY AVE ROCKVILLE, MARYLAND 20850	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-5-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Jos. Gaudin's Sons Inc.		25a. REC'D BY REGISTRAR Dr. C.	25b. REGISTRAR'S SIGNATURE Charles Judge

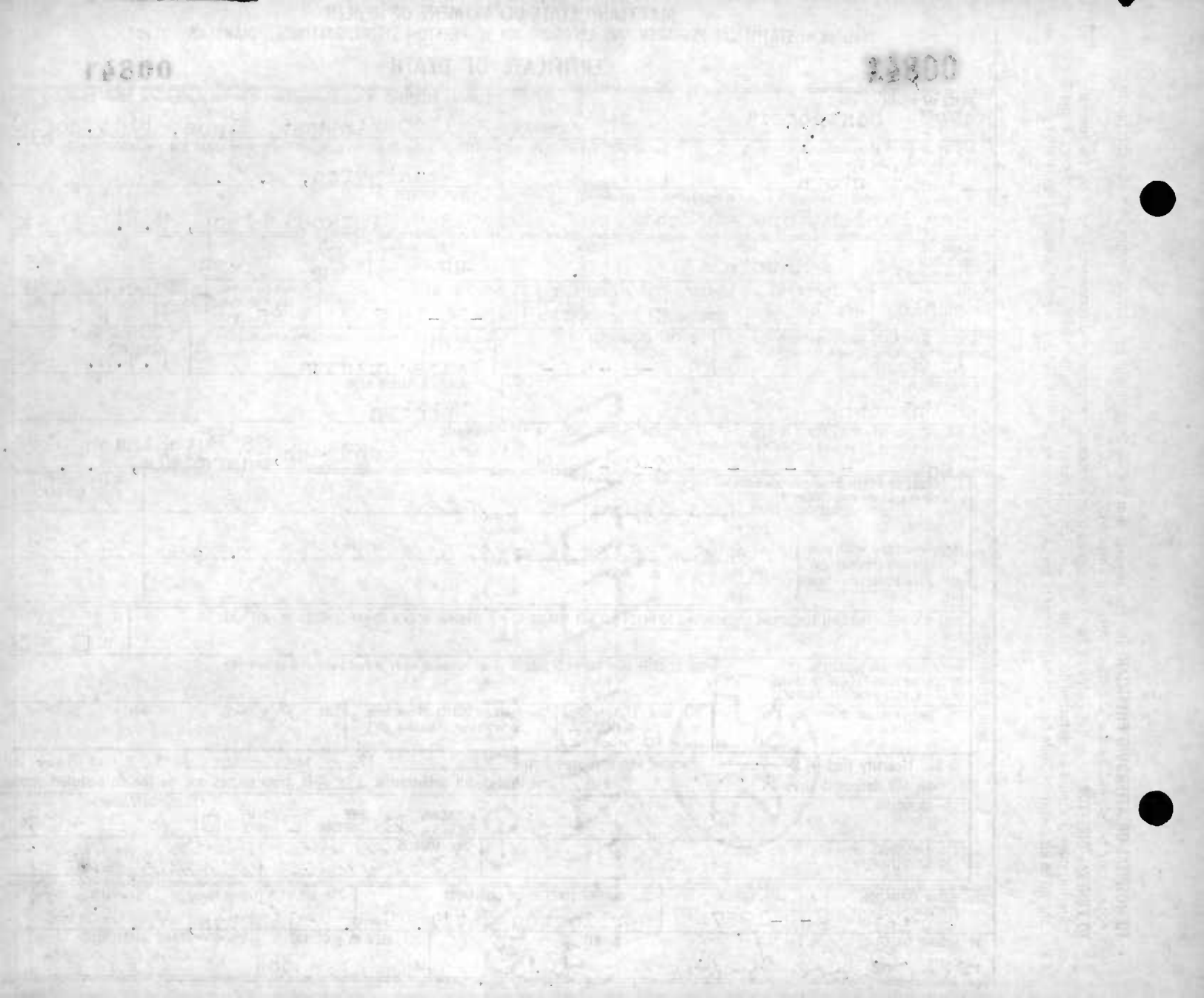
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14800

STATE OF TEXAS

14800



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00842

00842

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>4 Mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8007 Flower Ave.</u>		d. STREET ADDRESS <u>8007 Flower Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Edward Baggott</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) <u>47</u> yrs.
9. DATE OF BIRTH <u>8/27/1919</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tree-trimmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert H. Baggott</u>		14. MOTHER'S MAIDEN NAME <u>Grace B. Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>577-14-8559</u>	
17. INFORMANT <u>Betty Baggott - wife</u>		Address <u>7902 Garland Ave. Takoma Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot Gun Wound of Chest</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>8 October</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in chest with 16 gauge shotgun.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6-9</u> p.m. <u>1/31</u> 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Takoma Park, Mont. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>2/1/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		7936 Old Georgetown Rd. Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>1331 Rock. Pike Rockville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 3 1967</u>	

2386

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
00843		CERTIFICATE OF DEATH	
00843		00843	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ab. Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>3230 Chillum Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>N.</u> Last <u>Balderson</u>		4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>May 4, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Film Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Columbia Pictures</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry M. Jenis</u>		14. MOTHER'S MAIDEN NAME <u>Martha Marmaduke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-05-3287-A</u>	
17. INFORMANT <u>Beverley Suit</u>		Address <u>13402 Grenoble Drive Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Carcinoma of Breast</u> DUE TO (c) <u>170X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>66</u> , to <u>1/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>67</u> , and that death occurred at <u>12:04 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u>		22b. DATE SIGNED <u>1/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 20 1967</u>	

00843

00843

STATE OF TEXAS

County of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00844

Item 9 Film G384 1/19/67 mh

00844

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>19 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3700 - Bradley St NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>V.</u> Last <u>Ball</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/3/98</u> 49.68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Taylor Davis</u>				14. MOTHER'S MAIDEN NAME <u>Helen Hoff Coker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>William Davis, Suitland, Md.</u> Address <u>5627 Hilltop</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation - Cardiac Arrest</u> 561.4 DUE TO (b) <u>Acute Coronary Occlusion</u> DUE TO (c) <u>Large Incarcerated Hernia with Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2</u> , 19 <u>67</u> , to <u>Jan 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 11</u> , 19 <u>67</u> , and that death occurred at <u>7:30 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>J. W. Peabody Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. PEABODY JR. M.D.</u>				22d. ADDRESS <u>8512 OLD GEORGETOWN RD BETH.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. H. Morris</u> <u>Arlington Funeral Home</u>				25a. REC'D BY REGISTRAR <u>3001 N. Fairfax</u> <u>Arl., Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00844

UNITED STATES DEPARTMENT OF JUSTICE

100-100000

Division of Investigation

1967

Division of Investigation

00845

CERTIFICATE OF DEATH

00845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN tb <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>111914 Tilden Woods Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude</u>		4. DATE OF DEATH <u>January 12</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1907</u> 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>G.L. Bowen - son in law - same item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE UTERUS</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6</u> , 19 <u>66</u> , to <u>1/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/12</u> , 19 <u>67</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u>		22b. DATE SIGNED <u>1/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard Pollen</u>		22d. ADDRESS <u>10400 Connecticut Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>	23d. LOCATION (City or Town) (County) (State) <u>Lewistown Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>	
ADDRESS <u>1331 Rockville Pike</u> <u>Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2480

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classified with Md. Examiner Bulletin Reap No. 90
Bp

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00846					00846						
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Oakhaven Convalescent Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47.3</u> d. STREET ADDRESS <u>512 Fern Place N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Deborah</u> First <u>Bath</u> Middle <u>Bath</u> Last			4. DATE OF DEATH <u>1-23-</u> Month <u>1967</u> Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 8, 1888</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kennmare, Ireland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Callahan Shea</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Neill</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>097-09-8080B</u>		17. INFORMANT <u>Robert B. Bath</u> Address <u>512 Fern Place NW Wash. DC</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>years.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>10/30, 1966</u> to <u>1/23, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/23 1966</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James R Coleman MD</u>										22b. DATE SIGNED <u>1/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R COLEMAN</u>					22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>26 Jan. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>			
24. FUNERAL DIRECTOR <u>Rinaldi Funeral Home, Inc. 7400 Ga. Ave., N.W.</u>					25a. REC'D BY REGISTRAR <u>JAN 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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on 10/10/10 received from [illegible]

10/10/10

JAMES K. COLEMAN
JAMES K. COLEMAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00847		00847	
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rose Hill	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. STREET ADDRESS (No street address)	
3. NAME OF DECEASED (Type or print) First Middle Last Waco Denham Bays, Jr.		4. DATE OF DEATH Month Day Year January 24, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 December 1917
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Representative/Public Housing		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Waco D. Bays, Sr.		14. MOTHER'S MAIDEN NAME Nancy Weston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942-1945 405-18-0406	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 421.1 DUE TO Infection of aortic valve prosthesis with partial detachment of valve (b) DUE TO Aortic valve replacement for calcific aortic stenosis 10/25/66 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 weeks 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Jan. 13, 19 67, to Jan. 24, 19 67, that he (we) last saw the deceased alive on Jan. 24, 19 67, and that death occurred at 7:30, from the causes and on the date stated above.			
22a. SIGNATURE Hamner Hannah III		A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 24 January 1967	
22c. PHYSICIAN'S NAME (Type) Hamner Hannah III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-27-67	
23c. NAME OF CEMETERY OR CREMATORY Hubbard Springs		23d. LOCATION (City, town or county) (State) Jonesville, Virginia	
24. FUNERAL DIRECTOR E. R. Sturgill		25a. REC'D BY REGISTRAR JAN 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00862

CERTIFICATE OF DEATH

00862

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>1 hr 10 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulles</u>				d. STREET ADDRESS <u>Rt # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Randall</u> Middle <u>R</u> Last <u>Beitzel</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1916</u>	9. AGE (In years last birthday) <u>50</u> yrs.	10. IF UNDER 1 YEAR Months <u>22</u> Days <u>19</u> Hours <u>67</u>		11. IF UNDER 24 HRS. Months <u>22</u> Days <u>19</u> Hours <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Beitzel</u>				14. MOTHER'S MAIDEN NAME <u>Ida Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-6439</u>		17. INFORMANT <u>Wife (Lena) Same as above</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>157X</u> IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE PANCREAS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1966, to <u>1/22</u> , 1967, that (II) (we) last saw the deceased alive on <u>1/22</u> , 1967, and that death occurred at <u>10 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pollen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>				22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Beallsville Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>William C. Hilton</u>				ADDRESS <u>Barnesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00880

STATE OF TEXAS

00880

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00848

CERTIFICATE OF DEATH

00848

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT of COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 5019 Ames Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Irene Bell		4. DATE OF DEATH Month JANUARY Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 DECEMBER 1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 1 Days 26 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) St. MARY'S, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Henrietta Watts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-62-5771	
17. INFORMANT Son, David Bell		Address 5019 Ames Street Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Maturity Onset			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 25 JAN , 19 67 , to 26 JAN , 19 67 , that (I) (X) last saw the deceased alive on 26 JAN 1967 , and that death occurred at 1:25 PM , from causes and on the date stated above.			
22a. SIGNATURE R. J. Kinney		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY		22d. ADDRESS NAV HOSP BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 1-30-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) St. Mary's Va.
24. FUNERAL DIRECTOR Johnson & Jenkins		25a. REC'D BY REGISTRAR 4804 Ra. Ave. N.W.	
25b. REGISTRAR'S SIGNATURE Charles J. ...		DATE JAN 31 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00849

CERTIFICATE OF DEATH

00849

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 133 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland			d. STREET ADDRESS 5840 Marbury Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Marie Middle E. Last Bennett			4. DATE OF DEATH Month January Day 17 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1896		9. AGE (In years lost birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Hungary	
13. FATHER'S NAME John Ettl			14. MOTHER'S MAIDEN NAME Anna Horvath		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Probable Septicemia DUE TO (b) Carcinoma of the Colon DUE TO (c) lost.					INTERVAL BETWEEN ONSET AND DEATH 4 hours 21 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 6 , 1966, to Jan. 17 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 17 , 1967, and that death occurred at 1245 M, from causes and on the date stated above.					
22a. SIGNATURE C. Kiermey		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. P. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 17 January 1967	
22c. PHYSICIAN'S NAME (Type) Carl Kiermey, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-20-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR Jos. Sawlers		ADDRESS 5130 Wisg. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DATE JAN 20 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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P. 2899

5000

CERTIFICATE OF DEATH

00850

00850

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>9220 Whitney Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ralph Wesley Bennett</u>		4. DATE OF DEATH Month Day Year <u>January 19 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-91</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Springfield Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Bennett</u>		14. MOTHER'S MAIDEN NAME <u>? Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes U.S. Army</u>		16. SOCIAL SECURITY NO. <u>282-03-7228</u>	
17. INFORMANT <u>Sarah M. Bennett - 9220 Whitney St. S.S. Md.</u>		Address <u>Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary artery thrombosis</u> DUE TO (b) <u>Coronary artery arteriosclerosis</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Secondary polycythemia cerebral artery thrombosis.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 23, 1964</u> , to <u>January 19, 1967</u> , that (I) (we) lost sow the deceased alive on <u>January 19, 1967</u> , and that death occurred at <u>10:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Aaron H. Traum</u>		22b. DATE SIGNED <u>January 20 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>		22d. ADDRESS <u>8237 Georgia Ave - Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 26 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00850

CERTIFICATE OF DEATH

00850

Name of Deceased		Date of Birth		Date of Death	
Sex		Race		Place of Birth	
Marital Status		Occupation		Cause of Death	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Issuance		Place of Issuance		Official Seal	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00851

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00851

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b less than 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Browningsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS RFD #1 Monrovia	
3. NAME OF DECEASED (Type or print) Talmage Eugene Bennett		4. DATE OF DEATH Jan. 13, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	9. AGE (In years last birthday) 76 yrs.
11. BIRTHPLACE (County & State, or foreign country) Browningsville, Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Bennett		14. MOTHER'S MAIDEN NAME Sybelle Browning	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-0770	
17. INFORMANT Mrs. Libby W. Bennett		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 min 12 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatic Hypertrophy			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 10, 1935 to January 13, 1967 , that (I) (we) last saw the deceased alive on January 13, 1967 , and that death occurred at 10:40 M. from the causes and on the date stated above.			
22a. SIGNATURE M. McKendree Boyer		22b. DATE SIGNED January 13, 1967	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.		22d. ADDRESS 9701 Church Street, Damascus, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist	23d. LOCATION (City, town or county) (State) Browningsville, Maryland.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Maryland.		25a. REC'D BY REGISTRAR JAN 17 1967 25b. REGISTRAR'S SIGNATURE f Charles Judge	

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[Handwritten signature or initials]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00852

CERTIFICATE OF DEATH

00852

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN lb <u>4 mos</u>		d. STREET ADDRESS <u>68001 Riggs Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jacob</u> First <u>NMN</u> Middle <u>BERGman</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890</u>
9. AGE (In years lost birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Manager of Restaurant Bar</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Bergman</u>		14. MOTHER'S MAIDEN NAME <u>Sheindel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>063-16-3858</u>	
17. INFORMANT <u>SON</u> Address <u>1401 Blair M. H. Rd S.W. Spg. Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> (b) <u>Renal insufficiency</u> (c) <u>Arteriosclerotic cardiovascular dis.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>66</u> to <u>1/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>67</u> , and that death occurred at <u>2 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Peter Duus</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>PETER DUUS, MD.</u>		22d. ADDRESS <u>CAPITOL HTS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN FALLS CHURCH VA.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKI & SONS - WASH. DC</u> ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

00853

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTEG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>2204-RICHLAND PL.</u>	
3. NAME OF DECEASED (Type or print) <u>GUSSIE - BERSON</u>		4. DATE OF DEATH <u>January 20 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. - 1891</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESSMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>GODFREY FRANKEL</u>		Address <u>(SAME as 2x above)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Duct Bladder</u> DUE TO <u>155.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sept 1966</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>Jan 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 20</u> 19 <u>67</u> , and that death occurred at <u>3:30 a.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>BLAINE H. EIG</u>		22b. DATE SIGNED <u>Jan 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>8641 Colverville Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>1/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash. DC</u>
24. FUNERAL DIRECTOR <u>Godfrey Frankel Home 4279 Rockville Rd.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00883

CERTIFICATE OF DEATH

00883

UNKNOWN

1/10/67 George Allen Cor. Wash. D.C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00854

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb 11 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2232 Washington Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2232 Washington Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARROLL Middle J. Last BILBREY		4. DATE (Found) Month January Day 22 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 2, 1918
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 22 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument maker		10b. KIND OF BUSINESS OR INDUSTRY Bureau U.A. Govt. Weather	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis R. Bilbrey		14. MOTHER'S MAIDEN NAME Rosetta A. Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW11	
17. INFORMANT Carolyn L. Jones		Address 12400 Village Square Terr. Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty liver DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 1/23/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR DATE JAN 26 1967	
25b. REGISTRAR'S SIGNATURE Charles E. Wignall		25c. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

00855

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takome Park c. LENGTH OF STAY IN lb 4 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7324 Willow avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Morgan Dunstan Bingham		4. DATE OF DEATH Month January Day 27 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-05
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Highway Inspector		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James A Bingham		14. MOTHER'S MAIDEN NAME Alicia McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes army		16. SOCIAL SECURITY NO. 218-03-5775	
17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glaucoma DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 8 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 5, 1966 to Jan 27, 1967 , that (I) (we) last saw the deceased alive on Jan 27, 1967 , and that death occurred at 12 PM , from causes and on the date stated above.			
22a. SIGNATURE James L. Whitlock		22b. DATE SIGNED 1-28-67	
22c. PHYSICIAN'S NAME (Type) James L. Whitlock		22d. ADDRESS 7217 Canall Ave Takoma Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 2/1/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR The S.H. Hines		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 1 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00855

COMMITTEE OF DEATH

00855

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00856

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00856

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>83.3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A</u>		d. STREET ADDRESS <u>800 W. Princess Ann Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GUSTAVE</u>		4. DATE OF DEATH <u>JAN. 2 19 67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/01</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Area Manager - State of Israel Bonds</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Israel Bonds</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bisgyer</u>		OTHER'S MAIDEN NAME <u>Sarah Flomanhoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-0963</u>	
17. INFORMANT <u>Wife's son - nephew</u>		Address <u>7309 Ramonder Lane Chevy Chase, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>Jan 2, 1967</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Har Sinai</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REGISTRAR'S SIGNATURE <u>James Judge</u>	
25b. DATE <u>JAN 9 1967</u>		25c. REGISTRAR'S SIGNATURE	

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CERTIFICATE OF DEATH

00858

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		d. STREET ADDRESS <u>731-3rd ST. N. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Wallace</u> Middle <u>D.</u> Last <u>Bowling</u>		4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/07</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>28</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Smoker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Bowling</u>		14. MOTHER'S MAIDEN NAME <u>Marie Simpson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>220-28-15807</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>carcinoma</u> DUE TO (c) <u>indist.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/27/1967</u> to <u>1/28/1967</u> , that (I) (we) last saw the deceased alive on <u>1/27/1967</u> and that death occurred at <u>6:15 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. Philip Jones</u>		22b. DATE SIGNED <u>1/28/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George Co Maryland</u>
24. FUNERAL DIRECTOR <u>Nottingham Funeral Home Washington D.C.</u>		25. REC'D BY REGISTRAR DATE <u>FEB 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00058

CERTIFICATE OF DEATH

1950

1950

1950

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00858

CERTIFICATE OF DEATH

00857

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>5130 Connecticut Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Raymond</u> Last <u>Boylan</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-1891</u>
9. AGE (in years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Administration - Maritime Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James F. Boylan</u>		14. MOTHER'S MAIDEN NAME <u>--- Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Blanche M. Boylan - See Item 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis - acute - bronchial</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cause undetermined</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome - hypersensitive a.s.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>---</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1953</u> , to <u>Jan 31, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 30 1967</u> , and that death occurred at <u>1 P. M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. McMahon</u> M.D.		22b. DATE SIGNED <u>1-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. McMahon</u>		22d. ADDRESS <u>3000 Conn. Ave. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-3-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 3 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00521

STATE OF TEXAS

00880

WITNESSETH

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Austin, this 1st day of January, 1901.

00859

CERTIFICATE OF DEATH

00859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Heater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>2420 Seminary Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Elsie Harloff Branham</u>		4. DATE OF DEATH <u>Jan 5 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1899</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>67</u> Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - Secy.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Buffalo, New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Harloff</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Kahn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Mr. Donald K. Staley</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (new)</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Multiple Cerebral Hemorrhages old</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Under 1 week</u> <u>16 May 1966</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterial Hypertension</u> Arterial Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 19)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 6, 1965</u> to <u>Jan 5, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 4, 1967</u> and that death occurred at <u>12:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>George L. Ball</u>		22b. DATE SIGNED <u>Jan 5, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		22d. ADDRESS <u>10620 Georgia Ave Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pinehill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Buffalo, New York</u>	
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>JAN 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>434 Georgia Avenue Silver Spring, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00860

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00860

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10,007 Greeley Ave.</u>				d. STREET ADDRESS <u>10,007 Greeley Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernard William Brasso</u>				4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1920</u>	9. AGE (In years last birthday) <u>46 yrs.</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machines</u>		11. BIRTHPLACE (State or foreign country) <u>Forest City, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Watts Brasso</u>				14. MOTHER'S MAIDEN NAME <u>Rose Wargo</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Antoinette B. Brasso</u> Address <u>10007 Greeley Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination shock due to</u> DUE TO <u>Gunshot wound in neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Gunshot wound in neck</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased shot self in neck</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:20</u> p.m. <u>1-15</u> 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.				22. DATE SIGNED <u>JAN. 15, 1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (State, city, town, or county) <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u> Address <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00861

CERTIFICATE OF DEATH

00861

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN 1b <u>33 days</u>		d. STREET ADDRESS <u>3211 PAULINE DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BEVERLY</u> First <u>None</u> Middle <u>Brill</u> Last		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-34</u>
9. AGE (In years lost birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Phillip Steine</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE MAGAZINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANT LYMPHOMA (THYMUS)</u> 2002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UREMIA</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>63</u> , to <u>JAN 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JAN 2</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Krichmar</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT H. KRICHMAR</u>		22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>	23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH - VA.</u>
24. FUNERAL DIRECTOR <u>D. DANZAN SKY & SONS - WASHINGTON DC</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JAN 5</u>		19 <u>67</u>	

00880

UNITED STATES OF AMERICA

00880

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "UNITED STATES OF AMERICA" and "DEPARTMENT OF JUSTICE" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items #1c&2d 13 & 14 & 16 Film #G385 2/20/67

CERTIFICATE OF DEATH

Reg. Dist. No. 00863

00863

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring.		c. LENGTH OF STAY IN 1b 2 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn,	
3. NAME OF DECEASED (Type or print) First SARAH Middle B. Last BROMER		d. STREET ADDRESS 2620 2820/ Glenwood Road	
4. DATE OF DEATH Month January Day 31, Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1883
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua David Oberkowitz		14. MOTHER'S MAIDEN NAME Jennie David Shana	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 111/36/6145	
17. INFORMANT Mrs. Eleanor Sacks - DAU.		Address 9009 Garland Ave., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Caecum & sigmoides DUE TO 1530 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 9 mo DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 66 , to 31 Jan , 19 67 , that I last saw the deceased alive on 31 Jan , 19 67 , and that death occurred at 11 25 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 800 PERSHING DRIVE DATE SIGNED 31 Jan 67 ACTUAL SIGNATURE John H. Tublin M.D. SILVER SPRING, MD. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 2, 1967	22c. NAME OF CEMETERY OR CREMATORY BETH DAVID CEMETERY	22d. LOCATION (City, town, or county) (State) BROOKLYN, NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE Hysong Fun. Home, PER-Thomas M. Hysong Wash. D.C.		24a. REC'D BY REGISTRAR 1967	24b. REGISTRAR'S SIGNATURE 232 CARROLL WASH. D.C.

RELEASED TO: DONALD M. STEIN HEBREW MEM. F. H. 232 CARROLL WASH. D.C.

00863

CERTIFICATE OF MARRIAGE

00863

NAME OF BRIDE		NAME OF GROOM	
RESIDENCE OF BRIDE		RESIDENCE OF GROOM	
DATE OF MARRIAGE		PLACE OF MARRIAGE	
NAME OF MINISTER		NAME OF OFFICIAL	
SIGNATURE OF BRIDE		SIGNATURE OF GROOM	
SIGNATURE OF MINISTER		SIGNATURE OF OFFICIAL	
WITNESSES		WITNESSES	
SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
NAME OF REGISTRAR		NAME OF REGISTRAR	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
OFFICIAL SEAL		OFFICIAL SEAL	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00864

CERTIFICATE OF DEATH

00864

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San.		d. STREET ADDRESS 207 Bluff Terrace	
3. NAME OF DECEASED (Type or print) First Middle Last I D A B R O O K S		4. DATE OF DEATH Month Day Year Jan. 2, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 16, 1891
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Roumania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Kolmar		14. MOTHER'S MAIDEN NAME -----unknown-----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-18-6774	
17. INFORMANT Mrs. Eva Rochkind, same as 2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ARTERIOSCLEROSIS - GENERALIZED DUE TO 250 (c) ARTERIOSCLEROTIC HEART DISEASE DUE TO YRS.		INTERVAL BETWEEN ONSET AND DEATH HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 1, 1967 to JAN. 2, 1967 that (I) (we) last saw the deceased alive on JAN. 2, 1967 , and that death occurred at 9:41 M, from causes and on the date stated above.			
22a. SIGNATURE AH Grollman		22b. DATE SIGNED 1/3/67	
22c. PHYSICIAN'S NAME (Type) ALBERT H GROLLMAN		22d. ADDRESS 1106 SPRING ST. SILVER SPRING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-67	
23c. NAME OF CEMETERY OR CREMATORY Beth Tefiloh Cem.		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N.W.		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22800

43800

Cleared with Dr. Rupp for Dr. Traum to sign

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

00865

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>Do A.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 Wash. San + Hosp.</u>				d. STREET ADDRESS <u>9012 Piney Br. Rd # 202</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles Wilson Brown</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-14-14</u>	
9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DSF MGMT Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles W. Brown Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Annant Hughes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Charles W. Brown (Mrs)</u>				Address <u>Bethesda 02 + 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary artery insufficiency</u> DUE TO (b) <u>Coronary artery thrombosis</u> DUE TO (c) <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>42 days</u> <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Dec 2</u> , 19 <u>66</u> , to <u>Jan 13</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 29</u> , 19 <u>66</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Aaron H. Traum</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 13 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				22d. ADDRESS <u>8237 Georgia Ave - Silver Spring Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>		23d. LOCATION (City or Town) (County) (State) <u>PITTSBURG PENNA -</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>				ADDRESS <u>1406 Chapin St WASH. D.C. NW</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE				DATE <u>JAN 17 1967</u>			

23800

32830

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7,25 Film G384 1/12/67 mh

00866

CERTIFICATE OF DEATH

00866

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>9 Days</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase 1511</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>						d. STREET ADDRESS <i>12 W. Irving St</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>David</i>		Middle <i>W.</i>		Last <i>Brown</i>		4. DATE OF DEATH Month <i>JAN</i>		Day <i>5</i>		Year <i>1967</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/12/00</i>		9. AGE (In years last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland (Montgomery)</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>UNKNOWN</i>						14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>577-30-4140</i>		17. INFORMANT <i>Mrs.</i>						Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary insufficiency</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>As H. D.</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>62</i> to <i>Jan</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Jan 4</i> , 19 <i>67</i> , and that death occurred at <i>5:45 PM</i> , from causes and on the date stated above.													
22a. SIGNATURE <i>Marvin Wadler</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER</i>						22d. ADDRESS <i>8218 Wisc. Av. Beth., Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>1/9/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial Cem.</i>				23d. LOCATION (City or Town) <i>Suitland.</i>		(County)		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>John T. Rhines Co</i>						ADDRESS <i>3015 12 St N.E</i>		25a. REC'D BY REGISTRAR <i>JAN 9 1967</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00866

00866

John T. Kline to Secretary

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00867

CERTIFICATE OF DEATH

00867

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 117.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home				d. STREET ADDRESS 2115 Penn. A ve. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH D BROWN				4. DATE OF DEATH Month JAN Day 22 Year 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/1913	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) D. C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Virgle Brown				14. MOTHER'S MAIDEN NAME Rose Franklin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-09-5900		17. INFORMANT Evelyn M. Brown-wife Same as #2D			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma esophagus w/ metast DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 148X							INTERVAL BETWEEN ONSET AND DEATH 18 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to 1/22 , 19 67 , that (I) (we) last saw the deceased alive on 1/22 , 19 67 , and that death occurred at 2P M, from causes and on the date stated above							
22a. SIGNATURE John J. Lynch				22b. DATE SIGNED 1/22/67		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS 1234-19th St. N.W. WASH, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1.25.67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland. Maryland	
24. FUNERAL DIRECTOR Lee Funeral Home. 300.4th st N E				25a. REC'D BY REGISTRAR DATE JAN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13830

00881

STATE OF TEXAS

NOTICE

Warrant

for

Arrest

Warrant

for

Arrest

Warrant

for

Handwritten notes and stamps, including a large 'E' and 'D'.

Handwritten notes and stamps, including a large 'E' and 'D'.

Warrant

1921

Warrant

00868

CERTIFICATE OF DEATH

00868

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. LENGTH OF STAY IN 1b 15 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home 5141 Mass. Ave. N. W.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5141 Mass. Ave. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elisabeth Prender Buchanan First Middle Last		4. DATE OF DEATH Jan 20 19 67 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 31, 1892 9. AGE (In years last birthday) yrs. 74 1/2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Legal	11. BIRTHPLACE (County & State, or foreign country) D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Prender	
14. MOTHER'S MAIDEN NAME Sarah Chamblin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT S. N. Buchanan Address 5141 Mass. Ave. N. W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute coronary insufficiency DUE TO (b) Generalized arteriosclerosis DUE TO (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH few months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cause discussed with Dr. Ball		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1949 , 19 to Dec 2, 1966 that (I) (we) lost saw the deceased alive on Dec 2 19 66 and that death occurred at 445 M from causes and on the date stated above.		22a. SIGNATURE C P Ryland M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) C P RYLAND 22d. ADDRESS 4400-49 St NW	
22b. DATE SIGNED 1-20-67	23a. BURIAL, CREMATION, REMOVAL (Specify) 1/24/67		
23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home ADDRESS Washington, D. C.	25a. REC'D BY REGISTRAR DATE JAN 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00869		CERTIFICATE OF DEATH				00869			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u> <u>16-2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>					d. STREET ADDRESS <u>5709 Carter's Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marianne</u> First <u>Buckley</u> Middle Last			4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/66</u>		9. AGE (In years last birthday) yrs. <u>18</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mark Buckley</u>					14. MOTHER'S MAIDEN NAME <u>Louise May</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>At Above Address</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>340.2</u> IMMEDIATE CAUSE (a) <u>Purulent meningitis, acute</u> DUE TO (b) <u>Alpha streptococcus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>prematurity</u>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>66</u> , to <u>1/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/3</u> , 19 <u>67</u> , and that death occurred at <u>1:59</u> P.M. from causes on and on the date stated above.									
22a. SIGNATURE <u>Murray Paul</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/5/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>1040 Murray Paul, M.D.</u>					22d. ADDRESS <u>1040 University Blvd. E., Silver Spring Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>		
24. FUNERAL DIRECTOR <u>F. March Sons, Hyattsville, Md</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

00889

REPUBLIC OF DEBUT

00889

00870

CERTIFICATE OF DEATH

00870

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Arizona b. COUNTY 41.3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Aleck Budurin		4. DATE OF DEATH Month Day Year January 13, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 April 1921
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Veterinary	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kristof Budurin		14. MOTHER'S MAIDEN NAME Carolyn Isreal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1945		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 204.1 (b) Chronic Myelogenous Leukemia DUE TO (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from December 8, 19 66 to Jan. 13, 19 67 , that (#) (we) last saw the deceased alive on Jan. 13, 19 67 , and that death occurred at 9:25 M. from causes and on the date stated above.			
22a. SIGNATURE Roland T. Skeel, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 14 January 1967
22c. PHYSICIAN'S NAME (Type) Roland T. Skeel, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-15-67	23b. DATE THEREOF 1-15-67	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City or Town) (County) (State) Tucson, Arizona
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JAN 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00871

CERTIFICATE OF DEATH

00871

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falmouth		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital			d. STREET ADDRESS Route 2, Box 69		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lillian Middle Mae Last BURTON			4. DATE OF DEATH Month January Day 8 Year 19 67		
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1938	9. AGE (In years last birthday) yrs. 28	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Alfred Lloyd Meade			14. MOTHER'S MAIDEN NAME Bladys Bartee		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Linwood Ashby Burton, Rte 2, Box 69, Falmouth Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchial pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myeloblastic leukemia					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from Jan. 4 , 19 67 , to Jan. 8 , 19 67 , that (X) (we) last saw the deceased alive on Jan. 8 , 19 67 , and that death occurred at 355 PM , from causes and on the date stated above.					
21a. SIGNATURE Robert J. Kinney			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 9, 1967
22c. PHYSICIAN'S NAME (Type) Robert J. Kinney, M. D.			22d. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-11-67	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Spotsylvania County, Va.		
24. BURIAL DIRECTOR Wheeler & Thompson ADDRESS Funeral Home, Fredericksburg, Virginia			25a. REC'D BY REGISTRAR DATE JAN 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00872					00872						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY				
Montgomery			Silver Spring		Md.		Montgomery				
			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
			3 1/2 yrs.		Silver Spring Md		15-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			
9505 Thornhill Road					9505 Thornhill Rd			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)				
First Middle Last					Month Day Year		IF UNDER 1 YEAR IF UNDER 24 HRS.				
Mamie H. Camp					Jan. 15 1967		Months Days Hours Min.				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)			
female		white				March 2, 1871		95 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife					Own Home		Columbia, Georgia		U. S. A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
William R. Hairston					Julia Holloway						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT				
No					None		Mrs. Louise Proffitt				
					258-72-7621		Address 9505 Thornhill Rd. Silver Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										4 years	
443X											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO (b) Hypertensive Heart Disease											
DUE TO (c) Arteriosclerotic Heart Disease (senile myocarditis)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from Apr. 1963, to Jan. 1967, that (I) (we) last saw the deceased alive on Dec. 26 1966, and that death occurred at 2:10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
John N. Andrews											
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
John N. Andrews					9601 Colesville Rd Silver Spring Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial			Jan. 18, 1967		Decatur Cemetery		Decatur, Georgia				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE	
Clark E. Wisor					8434 Georgia Ave. Silver Spring, Md.					JAN 20 1967	
Warner E. Pumphrey, Inc.										Charles Judge	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Lanham (Hyattsville) 16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 7428 Jefferson Street	
3. NAME OF DECEASED (Type or print) DOMENICO CARAMANICO First Middle Last		4. DATE OF DEATH Month Jan Day 3 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 27, 1937 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	9. AGE (In years and birthday) 29 yrs.
11. BIRTHPLACE (County & State, or foreign country) Vasto, Italy		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Camillo Caramanico		14. MOTHER'S MAIDEN NAME Gracia Cifollilli	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578 52 1383	
17. INFORMANT Hayt G. Brown		3717 Quincy Street Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute nephritis with 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Agitation DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 26, 1966 to Jan 3, 1967 that (I) (we) last saw the deceased alive on Jan 3, 1967 and that death occurred at 2:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE William Brown		22b. DATE SIGNED 1/3/67	
22c. PHYSICIAN'S NAME (Type) W M BRAININ		22d. ADDRESS 6124 Central Ave, Capital Heights	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/6/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE JAN 5 1967	
25b. REGISTRAR'S SIGNATURE Francis Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00874**

FOR STATE
HEALTH DEPT

00874

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. LENGTH OF STAY IN 1b <i>D. O. A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Jennings</i> Last <i>Carlton</i>		4. DATE OF DEATH Month <i>January</i> Day <i>4</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 30, 1925</i>
9. AGE (in years last birthday) <i>41</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lithographer-Plate Maker Lithograph Co.</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Robert Jennings Carlton, Sr.</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Register</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Delitha J. Carlton</i> Address <i>613 Olney-Sandy Spring Rd. Sandy Spring, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxiation due to</i> <i>9731</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>carbon monoxide poisoning</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Deceased started auto in garage with no ventilation and sat in back seat</i>	
20c. TIME OF INJURY Hour <i>12:01</i> o. m. <i>1</i> - 4 1967 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Olney Montgomery Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Wheaton</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Belden R. Wheaton, Maryland</i>		11502 Grandview Ave. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 6, 1967</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. Glen Carter</i>		24a. REC'D BY REGISTRAR <i>Charles Judge</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>JAN 9 1967</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2012

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00875

CERTIFICATE OF DEATH

00875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
c. LENGTH OF STAY IN lb <u>22 hrs. 20</u>		d. STREET ADDRESS <u>Seven Locks Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Henry Carter</u>		4. DATE OF DEATH Month Day Year <u>Jan. 2 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>public school</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Henry Carter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Adelle Scott</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Lehia Nickerson</u> Address <u>Cabin John Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobular, confluent, bilat.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma prostate with metastases</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>67</u> , to <u>1-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-2</u> 19 <u>67</u> and that death occurred at <u>3:52</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>John J. Damm</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4 Jan 67</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cabin John, Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>		ADDRESS <u>Rockville Md.</u>	25a. REC'D BY REGISTRAR <u>9</u> 1967
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00875

00875

00876

CERTIFICATE OF DEATH

00876

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN Tb 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Michigan b. COUNTY Isabella c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Pleasant d. STREET ADDRESS Isabella Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle S. Last CASTILLO		4. DATE OF DEATH Month January Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1946
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Leatom, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lupie Z. Castillo		14. MOTHER'S MAIDEN NAME Stephena Sandobal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Feb 2, 1966 to Jan 376 44 9530		16. SOCIAL SECURITY NO. 376 44 9530	
17. INFORMANT Mr. Patrick Castillo		Address Michigan 3422 Sunnyview Dr./	
18. CAUSE OF DEATH (Enter only one label per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Penetrating Missile Wounds of the head DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Enemy Action	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Dec. 23 1966 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) South Viet Nam	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 6 , 1967, to Jan. 22 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 22 , 1967, and that death occurred at 330 PM , from causes and on the date stated above.			
22a. SIGNATURE P. B. Blanchard, M. D.		22b. DATE SIGNED Jan. 23, 1967	
22c. PHYSICIAN'S NAME (Type) P. B. Blanchard, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/24/67	23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery	23d. LOCATION (City or Town) (County) (State) Saginaw, Michigan
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D. C.		25a. REC'D BY REGISTRAR DATE JAN 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00877

CERTIFICATE OF DEATH

00877

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Silver Spring		d. STREET ADDRESS 9306 Flower Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leroy Magruder Childs		First Magruder Middle Childs Last Childs		4. DATE OF DEATH January 7 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/28/1893	
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer - Retired		11. KIND OF BUSINESS OR INDUSTRY Construction		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Theodore E. Childs		14. MOTHER'S MAIDEN NAME Emma W. Umstead		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army WWI	
16. SOCIAL SECURITY NO. 579-10-2825		17. INFORMANT Mr. Wm. Jackson		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Ethmoid 1607 DUE TO (b) Sinus E metastases to Brain DUE TO (c) abst 1 yr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from 5 Dec 1966 to 7 Jan 1967 , that (I) (we) last saw the deceased alive on 6 Jan 1967 , and that death occurred at 1:30 PM , from causes and on the date stated above.	
22a. SIGNATURE William Aud		22b. DATE SIGNED 11/7/67		22c. PHYSICIAN'S NAME (Type) William Aud, M. D.		22d. ADDRESS 9006 Colesville Rd., Silver Spring, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY St. John's Episcopal Cem.	
23d. LOCATION (City or Town) Olney, Maryland		24. FUNERAL DIRECTOR John B. Thomas		25a. REC'D BY REGISTRAR JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25d. REGISTRAR'S SIGNATURE Charles Judge		25e. ADDRESS 8434 Georgia Ave. Silver Spring, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Discussion

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(continued)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00878

00878

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>Mercer</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trenton</u>			
c. LENGTH OF STAY IN IB <u>5 days</u>				d. STREET ADDRESS <u>43 MORRIS AVE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph (nni) Christopher</u>			4. DATE OF DEATH Month Day Year <u>January 15 1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/1911</u>	9. AGE (in years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nociento Christopher</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>211-05-4251</u>		17. INFORMANT Address <u>Vincent Christopher 4309 Fernhill Road Wheaton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA TOSIS</u> <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CARCINOMA of Lung</u> (c) <u>about 1 yr.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>67</u> , to <u>1/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>67</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>				22d. ADDRESS <u>4115 Colie Drive, Wheaton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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00879

CERTIFICATE OF DEATH

00879

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>9004 Riggs Road</u>	
3. NAME OF DECEASED (Type or print) <u>Wesley Cowdin Clark</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-97</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Radio Station Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Maritime Comp. Mass.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rentham</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. American</u>	
13. FATHER'S NAME <u>George A. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Maude T. Cowdin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1918-1920</u>		16. SOCIAL SECURITY NO. <u>218-38-9372</u>	
17. INFORMANT <u>Jessie E. Clark - 9004 Riggs Rd. - Adelphi, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X</u> DUE TO (b) <u>Carcinoma of Rectum</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4th</u> , 19 <u>67</u> , to <u>Jan 15th</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 14</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lysle W. Williams</u> M.D.		22b. DATE SIGNED <u>1-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lysle W. Williams</u>		22d. ADDRESS <u>831 University Blvd E Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 18, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 19 1967</u>	

MEDICAL CERTIFICATION

Classified by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00273

00273

CHARTER OF DRAFT

1907

U.S. Marine Corps

1907-1908

1907-1908

00880

CERTIFICATE OF DEATH

00880

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL HOSPITAL				d. STREET ADDRESS 307 CHINLEE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alan Brian CLEVESY				4. DATE OF DEATH Month Day Year JANUARY 26 19 67			
5. SEX MALE		6. COLOR OR RACE CAUC		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 JAN 67	
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Mins		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) BETHESDA, MARYLAND	
13. FATHER'S NAME ROBERT A. CLEVESY				14. MOTHER'S MAIDEN NAME MARIE F. ADLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA		17. INFORMANT Address ROBERT A. CLEVESY 307 CHINLEE DR, LEXINGTON PARK MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ERYTHROBLASTOSIS 7705 DUE TO Prematurity with massive bilateral pulmonary atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 3hr 4min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from 26 JAN , 19 67 , to 26 JAN , 19 67 that (I) (we) lost saw the deceased alive on 26 JAN , 19 67 , and that death occurred at 0325M , from causes on and on the date stated above.							
22a. SIGNATURE <i>J.J. Tomasovic</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 27 January 67	
22c. PHYSICIAN'S NAME (Type) J.J. TOMASOVIC				22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE THEREOF 1-30-67		23c. NAME OF CEMETERY OR CREMATORY Linwood Cemetery		23d. LOCATION (City or Town) (County) (State) Haverhill, Mass.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

DEPARTMENT OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00881											
CERTIFICATE OF DEATH											
00881											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5207 Baltimore Avenue						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Lorain D. Cochran						4. DATE OF DEATH Month Day Year Jan. 19 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-1908		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sam DeLozier						14. MOTHER'S MAIDEN NAME Audra Elizabeth Read					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Albert L. Cochran- See Item No. 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 153.8 DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) GENERALIZED CARCINOMATOSIS (c), STATING THE UNDERLYING CAUSE LAST. CARCINOMA OF COLON										INTERVAL BETWEEN ONSET AND DEATH 15 MIN 2 YRS 5 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 15 1964 to JAN 19 1967, that (I) (we) last saw the deceased alive on JAN 18 1967, and that death occurred at 4:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. O'Connor						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/19/67			
22c. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR M.D.						22d. ADDRESS 8218 WISCONSIN AVE, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-24-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION (City, town or county) (State) Arlington, Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc.						ADDRESS 5130 Wisc. Ave. N.W. Wash. DC		25a. REC'D BY REGISTRAR DATE JAN 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00882

CERTIFICATE OF DEATH

Reg. Dist. No.

00882

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 15.1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5018 Malden St.				d. STREET ADDRESS 5018 Malden St.			
3. NAME OF DECEASED (Type or print) First Middle Last Douglas O. Collins				4. DATE OF DEATH Month Year Day JAN. 19 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-1876		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Jeweler		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Collins				14. MOTHER'S MAIDEN NAME Sarah Oliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Edith E. Collins- 5018 Malden Drive, Green Acres, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Prostate - 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Stage.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large abdominal aortic aneurysm.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from FEB 1952 to 19 JAN 1967 that I last saw the deceased alive on 18 JAN 1967 , and that death occurred at 3:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. H. Richwine M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 5522 WESTERN AVE 19 JAN 1967			
PHYSICIAN'S NAME (Type) A. H. RICHWINE				CHEVY CHASE, Md. 1967			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-21-1967		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons Inc. Wash. D. C.				24a. REC'D BY REGISTRAR JAN 24 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P.S.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salomas Manor</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Salomas Manor Nursing Home</u>		d. STREET ADDRESS <u>#9 Research Road.</u>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>J</u> Last <u>David</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	9. AGE (In years last birthday) <u>83</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Federick Bekastener</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Lloyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eunice Coffey (same @ #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X cerebral thrombosis</u> DUE TO (b) <u>atherosclerosis</u> DUE TO (c) <u>Thrombosis - popliteal artery</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>66</u> , to <u>1-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-29</u> , 19 <u>67</u> , and that death occurred at <u>12:35 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D.L. Bucy</u>		22b. DATE SIGNED <u>1-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.L. Bucy</u>		22d. ADDRESS <u>809 Veirs Mill Rd Rockville Mont Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>1/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Calverton Md. P.S. Md.</u>
24. FUNERAL DIRECTOR <u>Sasch's Son's Hyattsville, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. LENGTH OF STAY IN lb <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>				d. STREET ADDRESS <i>8403 11th Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HARRIETTE C. DAVIS</i>		First Middle Last		4. DATE OF DEATH <i>January 30, 1967</i>		Month Day Year	
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9 Feb 1882</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired dressmaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Garment</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Camden, New Jersey</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Harry Cheeseman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Seddinger</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>456-14-4525</i>		17. INFORMANT <i>Harry Buckley</i>		Address <i>8403 11th Avenue Silver Spring, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO (b) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>1 week</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-23, 1967</i> , to <i>1-30, 1967</i> , that (I) (we) last saw the deceased alive on <i>1-30, 1967</i> , and that death occurred at <i>5:30 p.m.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>Eino Magi</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1-30-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>				22d. ADDRESS <i>831 University Blvd E. Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Trans-burial</i>		23b. DATE THEREOF <i>Feb 2, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Camden, New Jersey</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>				ADDRESS <i>434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 2 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY in lb <u>5 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				d. STREET ADDRESS <u>2027 Glen Oak Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLARD</u> Middle <u>P</u> Last <u>Deakins</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip A Deakins</u>				14. MOTHER'S MAIDEN NAME <u>LORETTA GATES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>66</u> , to <u>1/20</u> , 19 <u>67</u> that (I) (we) lost the deceased alive on <u>1/20</u> , 19 <u>67</u> , and that death occurred at <u>11:45 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/20/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>F. Kreuzburg</u>		22d. ADDRESS <u>7552 16th Ave Wash DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-21-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Ellicott City, Md</u>	
24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>				25a. REC'D BY REGISTRAR DATE <u>23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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CENTRAL OF ALABAMA

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Handwritten signature or initials in the center of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

00886

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>1 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolf Hills Nursing Home</u>		d. STREET ADDRESS <u>10206 Carroll Place</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>W.</u> Last <u>DEAN</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>26</u> Year <u>19 67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Woodrow Wood</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Oakley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>242-64-8958-A</u>	
17. INFORMANT <u>Ruth Parker</u>		Address <u>10206 Carroll Place Kensington, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHITIS PNEUMONIA, due to</u> DUE TO (b) <u>CEREBRAL VASCULAR ACCIDENT, due to</u> DUE TO (c) <u>ATHEROSCLEROSIS, GEN'L AND CEREBRAL</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>2 MONTHS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 23, 1957</u> to <u>JAN 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 25, 1967</u> , and that death occurred at <u>10:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>1/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Avenue, Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Jan 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Granville County, N. C.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00336

CERTIFICATE OF CLAIM

00888

1. Name of claimant		2. Address of claimant	
3. Name of land		4. Location of land	
5. Date of claim		6. Name of agent	
7. Name of witness		8. Name of witness	
9. Name of witness		10. Name of witness	
11. Name of witness		12. Name of witness	
13. Name of witness		14. Name of witness	
15. Name of witness		16. Name of witness	
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93. Name of witness		94. Name of witness	
95. Name of witness		96. Name of witness	
97. Name of witness		98. Name of witness	
99. Name of witness		100. Name of witness	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00887

CERTIFICATE OF DEATH

00887

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sen. & Hospital</u>		d. STREET ADDRESS <u>1334 Rittenhouse St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosamond</u> Middle <u>De</u> Last <u>Boskey</u>		4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13 1910</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u>23</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Kiva Fishel</u>		14. MOTHER'S MAIDEN NAME <u>ESTHER LIBBY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with</u> DUE TO <u>myocardial infarction and congestive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>heart failure</u> DUE TO <u>heart failure</u> (b) <u>heart failure</u> (c) <u>heart failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>67</u> , to <u>1-23</u> , 19 <u>67</u> , that (I) (we) lost the deceased on <u>1-23</u> , 19 <u>67</u> , and that death occurred at <u>5:10 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert Hukwitz</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GILBERT HUKWITZ MD</u>		22d. ADDRESS <u>1800 EYE ST. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WATER MEM PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u> ADDRESS <u>4217-9th ST. N.W.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00887

INSTITUTE OF DESIGN

00887

Unknown

00888

CERTIFICATE OF DEATH

00888

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, BETHESDA, MD.		d. STREET ADDRESS 743 N. ALBEMARLE STREET	
3. NAME OF DECEASED (Type or print) MINERVA MINVERA (NMN) DELLAMANNA		4. DATE OF DEATH JANUARY 1 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 DECEMBER 1903
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) TRENTON, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MAX CROSNICK		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT PHYLLIS A. FURNARI, 743 N. ALBEMARLE STREET,		Address ARLINGTON, VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: SEVERE GENERALIZED ARTERIOSCLERATIC VASCULAR DISEASE, CEREBRAL AND CARDIAC IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 16 December, 1966 , to 1 January, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 January 1967 , and that death occurred at 10:45M , from causes and on the date stated above.			
22a. SIGNATURE G. T. Strickland		22b. DATE SIGNED 2 January 1967	
22c. PHYSICIAN'S NAME (Type) G. T. Strickland, LCDR MC USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/67	23c. NAME OF CEMETERY OR CREMATORY Calvary Memorial Park	23d. LOCATION (City or Town) (County) (State) Fairfax County, Virginia
24. FUNERAL DIRECTOR Arlington Funeral Home, 3901 No. Fairfax Dr. Arlington, Va.		25a. REC'D BY REGISTRAR JAN 5 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00889					00889				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> <u>15.1</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>12114 Grandview Avenue</u>				
3. NAME OF DECEASED (Type or print) <u>Anna</u>			First Middle Last <u>Anna</u>		4. DATE OF DEATH Month Day Year <u>1</u> <u>12</u> <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4-4-12</u>		9. AGE (In years last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jack Carpenter</u>					14. MOTHER'S MAIDEN NAME <u>Sally Roache</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Cassie Core Madison, Va.</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Hemorrhagic cerebral infarction, (R) temporal + occipital lobes</u> DUE TO (b) <u>Aneurysm (R) posterior cerebral artery.</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> , 19 <u>66</u> , to <u>1-12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-12</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Jonathan M. Williams</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-13-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Jonathan M. Williams</u>					22d. ADDRESS <u>808 Pershing Dr. Silver Spr.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town or county) (State) <u>Suitland P.G. Md.</u>		
24. FUNERAL DIRECTOR <u>Francis Rasch Sons Hyattsville, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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JACK S. BOBROW

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Colored by medical examiner 1/18/67 W.B.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00890

CERTIFICATE OF DEATH

00890

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 hr. 50 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp.</u>		d. STREET ADDRESS <u>618 Greenbrier Dr.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY LYSAGHT DETO</u>		4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-94</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Lysaght</u>		14. MOTHER'S MAIDEN NAME <u>Mary Haney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>578-09-9805D</u>	
17. INFORMANT <u>James Oliver Deto</u>		Address <u>618 Greenbrier Drive, Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Co. VA.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Genitally artus Delusio</u> DUE TO (c) <u>10412</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1942</u> to <u>Jan 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> <u>1967</u> , and that death occurred at <u>2:55 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Wardrop M.D.</u>		22b. DATE SIGNED <u>1-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP M.D.</u>		22d. ADDRESS <u>808 Parkway, Suite 201, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 23, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		25c. DATE <u>JAN 23 1967</u>	

09299

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00891

CERTIFICATE OF DEATH

00891

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>47-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home 11901 GA Ave Wheaton, Md.</u>		d. STREET ADDRESS <u>7055 Western Ave. NW</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian V. Dickson</u>		4. DATE OF DEATH <u>Jan. 18 1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-1899</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dist. of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McCullum</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Knight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Charles W. McCullum</u>		Address <u>7055 Western Ave. NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 1963</u> , to <u>JAN 1967</u> , that (I) (we) last saw the deceased alive on <u>18 JAN 1967</u> , and that death occurred at <u>11:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Goetz</u>		22b. DATE SIGNED <u>18 JAN 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOOZH MD</u>		22d. ADDRESS <u>2390 GLENMONT CIR WHEATON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-21-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>
24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
5130 Wisconsin Ave. N.W. Wash. D.C.		DATE <u>JAN 20 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
AIR FORCE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00892

CERTIFICATE OF DEATH

00892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>D. O. A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11007 Wheeler Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Norris</u> Middle <u>Richard</u> Last <u>Doubleday</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1920</u>
9. AGE (If years lost birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keplinger Wash. Editors Troy, N. Y.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Doubleday</u>		14. MOTHER'S MAIDEN NAME <u>Edith Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>085-16-5136</u>	
17. INFORMANT <u>Helen Louise Doubleday</u>		Address <u>11007 Wheeler Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis & myocardial infarction</u> DUE TO <u>4/20.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery sclerosis & generalized card-vas dis 2 yrs.</u> DUE TO (c) <u>Hypertension, moderate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anteal coarctates</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>67</u> , to <u>10 Jan, 1967</u> , that (I) (we) last saw the deceased alive on <u>9 Jan 1967</u> , and that death occurred at <u>4:47 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D.		22b. DATE SIGNED <u>12 Jan 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon, M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JAN 12 1967</u>	
25b. REGISTRAR'S SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00893

00893

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Colonial Villa Convalescent Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47.3 d. STREET ADDRESS 1656 Park Rd., N.W., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frances Douglas		4. DATE OF DEATH Month Day Year Jan 24 1967		5. SEX Female			
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 April 1887			
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator		10b. KIND OF BUSINESS OR INDUSTRY telephone company		11. BIRTHPLACE (County & State, or foreign country) Ohio			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Douglass		14. MOTHER'S MAIDEN NAME Florence unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-26-9114		17. INFORMANT Address Eleanor Francella, 11807 Indigo Rd., S.S., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Vulva</i> 176.0 DUE TO <i>with metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 6, 1966</i> to <i>Jan 24, 1967</i> that (I) (we) last saw the deceased alive on <i>Jan 21, 1967</i> and that death occurred at <i>1:00 PM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Neil P. Campbell</i> M.D.			22b. DATE SIGNED <i>1/24/67</i>				
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell			22d. ADDRESS 1629 Columbia Rd.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 26 Jan. 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			
23d. LOCATION (City, town or county) (State) Silver Spring, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc. 7400 Ga. Ave., NW					
25a. REC'D BY REGISTRAR DATE JAN 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00894

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00894

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 1903 August Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Douglas				4. DATE OF DEATH Month January Day 23 Year 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/27/12		
				9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		
						IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver			10b. KIND OF BUSINESS OR INDUSTRY transportation		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Clay Douglas				14. MOTHER'S MAIDEN NAME Mary Vanetta Cox				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Aunt, Bertha Cox Address 1903 August Dr Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22. DATE SIGNED JAN. 24, 1967								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/26/1967		23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City or Town) (County) (State) Wash. D.C.		
24. FUNERAL DIRECTOR Robert A. Mattingly ADDRESS 131-11th St				25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

00884

Longevity

Bertrand

Edward Spring

DOA

Silver Spring

1903 August Drive

Holy Cross Hospital

January 29

Douglas

Edward

William

24

1903 12

Male White

USA

Washington, D.C.

Transportation

Text driver

Mary Yvette Cox

William Cary Douglas

1903 August 21

211 Spr. St.

Porting Cox

No

00895

CERTIFICATE OF DEATH

00895

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITORIUM		d. STREET ADDRESS 2928 CONN. AVE. N. W.	
3. NAME OF DECEASED (Type or print) First MOLLIE Middle THOMAS Last DULIN		4. DATE OF DEATH Month JANUARY Day 21 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 23/1870
10a. USUAL OCCUPATION (Give kind of work done during last 14 days, if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY - - -	9. AGE (In years lost birthday) yrs. 96
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT U. S. A.	
13. FATHER'S NAME FRANK M. EMBREY		14. MOTHER'S MAIDEN NAME HARRIET S. SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. GRACE SHAW		Address 2928 CONN. AVE. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXHAUSTION and DEHYDRATION DUE TO BRONCHOPNEUMONIA, TERMINAL DUE TO CEREBRAL THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 6 DAYS 2 WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/26/67 to 1/21/67 , that (I) (we) last saw the deceased alive on 1/21/67 , and that death occurred at 9:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Horace H. Custis Jr.		22b. DATE SIGNED 1/21/67	22c. PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR.
22d. ADDRESS 1852 COLUMBIA RD NW-DC		22e. ADDRESS WASHINGTON	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/24/67	23c. NAME OF CEMETERY OR CREMATORY cedar HILL Cemetery	23d. LOCATION (City or Town) (County) (State) PRINCE GEO. CO.
24. FUNERAL DIRECTOR JOSEPH GAWLER SONS		25a. REC'D BY REGISTRAR DATE JAN 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00835

00835

COMPTON

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit receipt. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00896

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00896

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 10812 Childs St.	
3. NAME OF DECEASED (Type or print) First Lewis Middle Manley Last Durham		4. DATE OF DEATH Month January Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/06
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		11. BIRTHPLACE (State or foreign country) Chapel Hill Orange Co., No. Car.	
13. FATHER'S NAME James Durham		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 215-44-8554	
17. INFORMANT Wife, Address Betty Durham 10812 Childs St. S.S., Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO (b) Coronary Artery Heart Disease DUE TO (c) Coronary Artery Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25. REC'D BY REGISTRAR Jan 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

00897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00897

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4740 Bradley Blvd.</u>		d. STREET ADDRESS <u>4740 Bradley Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD LEO DYER</u>		4. DATE OF DEATH <u>JAN 3 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1893</u>
9. AGE (In years <u>73</u> yrs.)		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conn Edison-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Edward Dyer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>050-07-2638</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>lost.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>JAN. 4, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street, city, town, or county) <u>4740 Bradley Blvd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00897

00897

Handwritten notes and signatures, including "JAN 4 1967" and "JAN 4 1967".

Count Germany
Germany (West) & others

12/16/67
Biden R. Kennedy
JAN 4 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00898

CERTIFICATE OF DEATH

00898

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b WHEATON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 11305 AMHERST	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES W EASTON		4. DATE OF DEATH Month Day Year JANUARY 14 1967	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/84
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Marshall Easton		14. MOTHER'S MAIDEN NAME Martha Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-8624	
17. INFORMANT Son		18. ADDRESS 214 Cedar Ave. Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/1/66 , 19__ to 1/14/67 , 19__, that (I) (we) last saw the deceased alive on 1/14/67 , 19__, and that death occurred at 10 P M, from causes and on the date stated above.			
22a. SIGNATURE Patrick C. Jameson M.D.		22b. DATE SIGNED 1/14/67	
22c. PHYSICIAN'S NAME (Type) Patrick C. Jameson		22d. ADDRESS 11718 Georgia Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-67	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Md.		25a. REC'D BY REGISTRAR DATE JAN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00038

LIBRARY OF CONGRESS

00038

LIBRARY OF CONGRESS
SERIALS ACQUISITION
10540 JEFFERSON AVENUE
WASHINGTON, D.C. 20540

00899

CERTIFICATE OF DEATH

00899

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 601 Broadwood Drive		d. STREET ADDRESS 601 Broadwood Drive	
3. NAME OF DECEASED (Type or print) GRACE D. ELGEN		4. DATE OF DEATH Month January Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/84
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Luther Donaldson		14. MOTHER'S MAIDEN NAME Hannah Reppert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-46-6907	
17. INFORMANT Grace McGuire-Item# 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) year		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1959 , to Jan. 30, 1967 , that (I) (we) last saw the deceased alive on Jan. 29, 1967 , and that death occurred at 1:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE G. Bowditch Hunter, Jr.		22b. DATE SIGNED 1/30/67	
22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr.		22d. ADDRESS 50 W. Edmonston Dr., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Prince George Co., Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR JAN 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film G305 1/24/67 mh
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00900

00900

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Do A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8606 Jones Mill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Bentley</u> Middle <u>Eubanks</u> Last		4. DATE OF DEATH <u>Jan 10 1967</u> Month <u>Jan</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>15</u> Min. <u>15.1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep. Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Adm. Exec.</u>	
11. BIRTHPLACE (State or foreign country) <u>Denver, Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Eubanks</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Bentley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Same as above</u>	
17. INFORMANT <u>Wife Mary Eubanks</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute-</u> DUE TO (b) <u>Cardio-Vascular Disease-</u> stating the underlying cause lost. (c) <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>1/10/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25. REC'D BY REGISTRAR <u>JAN 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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[Faint, illegible handwriting]

Colonel J. H. ...
...

[Faint, illegible handwriting]

[Faint, illegible handwriting]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
00901					CERTIFICATE OF DEATH					00901				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>19 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>					d. STREET ADDRESS <u>6614 MELODY LANE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>LEE</u> Last <u>FETTY</u>					4. DATE OF DEATH Month <u>JAN.</u> Day <u>21</u> Year <u>1967</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 5, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>			11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>MOSES L. SHRIVER</u>					14. MOTHER'S MAIDEN NAME <u>ORPHA MORRIS</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>MRS. IRENE VAN ROYEN, SAME AS # 2</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>2 wk</u> <u>10 yr</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 2, 1967</u> to <u>JAN 21, 1967</u> that (I) (we) last saw the deceased alive on <u>JAN 21, 1967</u> , and that death occurred at <u>745 PM</u> , from causes and on the date stated above.														
22a. SIGNATURE <u>Ronald W. Barr</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR</u>					22d. ADDRESS <u>10401 OLD GEORGETOWN RD BETHESDA MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>			23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE MARYLAND</u>							
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER SONS</u> <u>5130 WISC. AVE. N. W. WASH., D.C.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judd</u>							

10299

13202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00902

CERTIFICATE OF DEATH

00902

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Washington, D.C.		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital						d. STREET ADDRESS 2006 Columbia Rd. NW						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Miss Nellie (none) Fielding						4. DATE OF DEATH January 21, 1967							
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-30-82		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chamber of Commerce				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? America			
13. FATHER'S NAME Mr. William Fielding						14. MOTHER'S MAIDEN NAME Annie Strahorn							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Patient's chart.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) Brachygonorrhea DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) Generalized arteriosclerosis												INTERVAL BETWEEN ONSET AND DEATH several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 66 , to Jan 24 , 19 67 , that (I) (we) last saw the deceased alive on Jan 23 , 19 67 , and that death occurred at 1:42 PM , from causes and on the date stated above.													
22a. SIGNATURE R. H. Sandstrom MD						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-24-67					
22c. PHYSICIAN'S NAME (Type) R. H. Sandstrom MD						22d. ADDRESS 7701 Carroll Ave Takoma Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/26/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.							
24. FUNERAL DIRECTOR The S. H. Hines Co. Washington D. C.						25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE f Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Richard H. S.

1911-12-12

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FOR STATE HEALTH DEPT.

00903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00903

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4922 Naples Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>NICCOLE IRENE FIZER</u>		4. DATE OF DEATH <u>JAN. 31 19 67</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1966</u>
9. AGE (In years lost birthday) yrs. <u>5</u> Months <u>29</u> Days <u>29</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Silver Spring, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Neil B. Fizer</u>		14. MOTHER'S MAIDEN NAME <u>Geneva K.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Neil Fizer</u> Address <u>Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Acute Bronchitis</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>JAN. 31, 1967</u>	
23a. BURIAL, CREMATION, — REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR <u>Donald Raymond Lawler</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
		DATE <u>FEB 6 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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00904

CERTIFICATE OF DEATH

00904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>4 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Myrtle Claudia Flinkingshelt</u> First Middle Last 4. DATE OF DEATH <u>January 24</u> 19 <u>67</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-18</u> 9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Claude A. Parnell</u>	
14. MOTHER'S MAIDEN NAME <u>Ethel Tribble</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Roy Charles Flinkingshelt</u> Address <u>431 University Blvd Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X ACUTE MYOCARDIAL INFARCT</u> DUE TO (b) <u>HYPERTENSIVE HEART DISE</u> DUE TO (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YRS</u> <u>YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>August 1966</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 24</u> , 19 <u>67</u> , to <u>JAN 24</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>JAN 24</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> P. M. from causes and on the date stated above.			
22a. SIGNATURE <u>Albert Abraham W. Danish</u>		22b. DATE SIGNED <u>JAN. 24, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT ABRAHAM W. DANISH</u>		22d. ADDRESS <u>1106 SPRING ST SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Trans-burial</u>	<u>Jan 28, 1967</u>	<u>Long Branch Cemetery</u>	<u>Anderson County, S. Carolina</u>
24. FUNERAL DIRECTOR <u>Clark & Wilson</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>	
ADDRESS <u>8434 Georgia Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>			

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STATE OF TEXAS

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ACUTE MYOCARDIAL INFARCT
HYPERTENSIVE HEART DISEASE
DIABETES MELLITUS

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-11-01 BY 1043

00905

CERTIFICATE OF DEATH

00905

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 7 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home						d. STREET ADDRESS 4503 Dabney Drive					
3. NAME OF DECEASED (Type or print) Lloyd Charles French						4. DATE OF DEATH Month 1 Day 9 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 4/28/1907		9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months 9 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Communications Supervisor				10b. KIND OF BUSINESS OR INDUSTRY 9. 7. & 7.		11. BIRTHPLACE (County & State, or foreign country) Providence, R. I.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. French						14. MOTHER'S MAIDEN NAME Alice Joy (Joy)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII				16. SOCIAL SECURITY NO. 088-05-4031		17. INFORMANT Mrs. L. C. French-Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Organic Brain Atrophy DUE TO 355X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 66 , to 1-9-67 , 19 67 , that (I) (we) last saw the deceased alive on 1-9 , 19 67 , and that death occurred at 6:40 PM , from causes and on the date stated above.											
22a. SIGNATURE Morris Perry						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-9-67			
22c. PHYSICIAN'S NAME (Type) Dr. Morris Perry						22d. ADDRESS 11602 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Purphrey, Inc.				ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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EXTRACT OF DEATH

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00906

CERTIFICATE OF DEATH

00906

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3529 Woodbine St.</u>	
3. NAME OF DECEASED (Type or print) <u>Burton</u> First <u>Fuller</u> Middle Last		4. DATE OF DEATH <u>Jan 27</u> 19 <u>67</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>El Paso Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lucius K. Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Ridley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>Yes Army</u>		16. SOCIAL SECURITY NO. <u>577-58-6505</u>	
17. INFORMANT <u>Wife</u> Address <u>Same as Item 2.</u>		Mrs. Elithe P. Fuller	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Rheumatic/Valvular Heart Disease with Regurgitation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 month</u> <u>40 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 18</u> , 19 <u>63</u> , to <u>Jan 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 25</u> 19 <u>67</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Favell</u>		22b. DATE SIGNED <u>1-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Favell</u>		22d. ADDRESS <u>5516 Nebraska Ave - D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIPT OF DEBIT

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FOR STATE
HEALTH DEPT.

00907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00907

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8719 Piney Br Rd</u>				d. STREET ADDRESS <u>8719 Piney Br Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine Virginia Gangloff</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10-31-09</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Arthur L. Haislip</u>				14. MOTHER'S MAIDEN NAME <u>Wepie Teco Oliver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Dr Reap + Police Record.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>465X</u> IMMEDIATE CAUSE (a) <u>Acute massive pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <u>Jan, 20, 1967</u>
ACTUAL SIGNATURE <u>Golden Reap, MD</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELOEN R. REAP M.D.</u>		Address (Street, city, town, or county)					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jan 24-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walter</u>		ADDRESS <u>254 G Street NE</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00908

CERTIFICATE OF DEATH

00908

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b 10 MOS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNIVERSITY NURSING HOME		e. STREET ADDRESS 608 59th AVENUE	
3. NAME OF DECEASED (Type or print) First HAROLD Middle VAN FOSSEN Last GARBER		4. DATE OF DEATH Month JANUARY Day 7 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1892
9a. AGE (In years last birthday) yrs. 74		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV.	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALLEN J. GARBER		14. MOTHER'S MAIDEN NAME ELLEN ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO.	
17. INFORMANT DONALD J. GARBER		Address 624 61AVE. CAPITOL HGTS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) Generalized Arteriosclerosis DUE TO (b) with cerebral insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 19 1959 , 19 59 to Jan 2, 1967 , that (I) (we) last saw the deceased alive on Jan 2 1967 , and that death occurred at 6:45 M, from causes and on the date stated above.			
22a. SIGNATURE William Brainin		22b. DATE SIGNED 1/7/67	
22c. PHYSICIAN'S NAME (Type) WM BRAININ		22d. ADDRESS 6124 Central Ave, Capitol Hgts	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/10/67	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND	
24. FUNERAL DIRECTOR WILHELM FUNERAL HOME		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS 4308 SUITLAND ROAD, SUITLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

00308

00308

UNITED STATES OF AMERICA

IN SENATE

WITNESSETH

THAT I HEREBY CERTIFY

TO THE SENATE

THAT THE FOLLOWING

RESOLUTION HAS BEEN PASSED

BY THE SENATE

THIS

DAY

OF

1900

ADJOURNED

AT WASHINGTON

THIS

DAY OF

1900

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00909

CERTIFICATE OF DEATH

00909

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>2 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>10413</u> <u>10413 Haywood Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>M.</u> Last <u>GARDINER</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/04</u> <u>05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. CONSTRUCTION SUPERINTENDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paving Contracts</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel L. Gardiner</u>		14. MOTHER'S MAIDEN NAME <u>Annie Jane Grigsby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Dorothy C. Gardiner</u>		Address <u>10413 Haywood Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Essential Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>Jan 3</u> , 19 <u>67</u> , to <u>Jan 5</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>Jan 5</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> p.m. from causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Dwyer, M.D.</u>		22b. DATE SIGNED <u>1/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>		22d. ADDRESS <u>10620 GEORGIA AVE, SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>JAN 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

29200

90200

00910

CERTIFICATE OF DEATH

00910

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>16 Days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>15.1</u>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Ra</u> Last <u>Dates</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/11</u>
9. AGE (in years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Radford's Rest.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Grady</u>		14. MOTHER'S MAIDEN NAME <u>Molly Butt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-0906</u>	
17. INFORMANT <u>Leving-Husband - Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Bronchopneumonia</u> DUE TO (b) <u>intestinal obstruction</u> DUE TO (c) <u>Abdominal Adhesions</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>Jan 13 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 13 1967</u> , and that death occurred at <u>11:47 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Daniel Powers</u>		22b. DATE SIGNED <u>1/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Daniel Powers</u>		22d. ADDRESS <u>50 W. Edmondston Drive, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JAN 17 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 4-64

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
009111					009111						
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			c. LENGTH OF STAY IN 1b <i>10 1/2 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1907 Forest Dale Drive</i>					d. STREET ADDRESS <i>1907 Forest Dale Drive</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ROSE</i>			First Middle Last <i>Belle GERARD</i>		4. DATE OF DEATH <i>JANUARY 21</i>		Month Day Year <i>19 67</i>				
5. SEX <i>female</i>		6. COLOR OF RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 6, 1873</i>		9. AGE (In years last birthday) <i>93</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Philip Fletcher</i>					14. MOTHER'S MAIDEN NAME <i>Rebecca Dayton</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>220-48-9518-91</i>		17. INFORMANT <i>Mrs. Alice G. Romer</i>		Address <i>1907 Forest Dale DR. Silver Spring, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 CONGESTIVE HEART FAILURE</i> DUE TO (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> <i>over 16 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 8</i> , 19 <i>50</i> , to <i>JAN. 21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>JAN. 21</i> , 19 <i>67</i> , and that death occurred at <i>9:20 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Israel Kessler</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>JAN. 21, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>ISRAEL KESSLER M.D.</i>						22d. ADDRESS <i>5801-16 ST. N.W. WASH. D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Jan 24, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Switland, Maryland</i>				
24. FUNERAL DIRECTOR <i>Glen Carter</i> <i>Warner E. Humphrey, Inc. Silver Spring, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>JAN 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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CERTIFICATE OF DEATH

00912

00912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>				d. STREET ADDRESS <u>8131-15th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Gershowitz</u> Last <u>Gershowitz</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/13</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Appel</u>				14. MOTHER'S MAIDEN NAME <u>Anna Maverman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harold Gershowitz</u> Address <u>3413 Canberra St.</u> <u>Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>330X</u> IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, left</u> DUE TO (b) <u>distended intercranial aneurysm</u> DUE TO (c) <u>9 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> , 19 <u>67</u> , to <u>Jan 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 21</u> , 19 <u>67</u> , and that death occurred at <u>8:22 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Sydney Leventhal</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>				22d. ADDRESS <u>9210 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Ch., Virginia</u>	
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>				ADDRESS <u>3501-14th St., N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 25 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

21200

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1
FOR STATE
HEALTH DEPT.

Items 18&21 Film 387 3 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00913

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lakoma Park				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium				d. STREET ADDRESS 11634 Deborah Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				15.1			
3. NAME OF DECEASED (Type or print) First Maude Middle Moore Last Gibson				4. DATE OF DEATH Month January Day 23 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1880	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min.	IF UNDER 24 HRS. Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Manfred M. Moore			
14. MOTHER'S MAIDEN NAME Elizabeth Perrin				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. 210 05 4475				17. INFORMANT William A. Gibson Jr. son Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pulmonary embolism; 465x DUE TO Bronchogenic carcinoma, right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap				22. DATE SIGNED JAN. 24, 1967			
EXAMINER'S NAME (Type) Belden R. Reap				11502 Grandview Address (Street, city, town, or county) Wheaton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Beachwood Cemetery	
23d. LOCATION (City, town or county) (State) Jefferson County Pennsylvania				24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home			
ADDRESS 1331 Rockville Pike				25a. REC'D BY REGISTRAR Pike			
DATE JAN 27 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00011

ANNUAL EXAMINER CERTIFICATE OF DEATH

00011

1911

[Faint, mostly illegible text from a form, likely a death certificate. The text is mirrored across the page, suggesting a bleed-through from the reverse side. Discernible fragments include:]

...of the County of ... State of ...

... on the ... day of ... 1911 ...

... at the residence of ...

... Cause of Death ...

... Signed and sworn to before me this ... day of ... 1911 ...

... Registrar of Deaths ...

... Medical Examiner ...

... Coroner ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00914

CERTIFICATE OF DEATH

00914

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 5504 Montgomery Street	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle NMI Last GIUFFRIDA		4. DATE OF DEATH Month Jan. Day 22 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Shoe Findings	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carmelo Giuffrida		14. MOTHER'S MAIDEN NAME Josephine (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT E. Leonard Messick		Address Adelphi, Md. 10142 Riggs Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO (b) atherosclerotic CV Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction 1958		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV. 19 60 to THE PRESENT that (I) (we) last saw the deceased alive on DEC 10 19 60 and that death occurred at 1:33 PM , from causes and on the date stated above.			
22a. SIGNATURE Edward W. Youngblood M.D.		22b. DATE SIGNED 1/22/67	
22c. PHYSICIAN'S NAME (Type) Edward W. Youngblood		22d. ADDRESS 8606 Ewing Drive, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/25/67	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR JAN 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00011

RECEIVED OF DEPT

00011



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00915

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>3709 Jeffry Street</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>JENKINS</u> Last <u>GLADMON</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wakefield, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Carpenter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>578-46-9188</u>		17. INFORMANT Address <u>Sil. Sp., Md.</u> <u>Mrs. Margaret Poole - 3709 Jeffry St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute Coronary Insufficiency</u> DUE TO <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Heart Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>JAN. 29, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP</u>		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00916

CERTIFICATE OF DEATH

00916

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN TB <u>34 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>989 SILVER SPRING</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SANITARIUM + HOSPITAL</u>				d. STREET ADDRESS <u>9823 E. LIGHT DR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS EARL GONZALEZ</u>				4. DATE OF DEATH Month Day Year <u>1 27 1967</u>			
5. SEX <u>M</u>	6. CILDR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-12</u>	9. AGE (In years lost birthday) yrs. <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RADIO TECH - C/P TELEPHONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>KANSAS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN Gonzales</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hira</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>579-01-3004</u>		17. INFORMANT <u>Gertrude Gonzales</u> Address <u>9823 E. Light Dr Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Pulmonary Edema</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Hydrops</u> DUE TO (c) <u>Cerebral of Liver.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-24</u> , 19 <u>66</u> , to <u>1-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-27</u> , 19 <u>67</u> , and that death occurred at <u>6:58</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Morton Altschuler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Morton Altschuler, MD</u>				22d. ADDRESS <u>9205 - New Hope Ave Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 31, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00316

STATE OF DEATH

00316

1-27-22

1-27-22

1-27-22

1-27-22

1-27-22

Morton Altshuler, 2122 W. 1st St. S. S. 1922

State of Kansas, County of Shawnee, City of Topeka, Kansas, 1-27-22

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00917

CERTIFICATE OF DEATH

00917

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>Richmond Manassas</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Richmond</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Richmond</u> d. STREET ADDRESS <u>Richmond Ave. Rt 1 Box 185</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Calvin Goode</u>		4. DATE OF DEATH Month Day Year <u>January 7 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Record</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John G. Goode</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Medical Record</u>	
17. INFORMANT <u>Medical Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Carcinoma of lung</u> DUE TO (c) <u>8-12 mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1966</u> to <u>Jan 7 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 7 1967</u> , and that death occurred at <u>11:07 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Oliver</u>		22b. DATE SIGNED <u>Jan 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Memory Garden</u>		23d. LOCATION (City or Town) (County) (State) <u>Manassas Virginia</u>	
24. FUNERAL DIRECTOR <u>Francis Darch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

CERTIFICATE OF DEATH

00918

00918

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 16-2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRLAND NURSING HOME				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8208 NEW HAMPSHIRE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ADA		First ADA		Last GOODMAN		4. DATE OF DEATH Month JANUARY Day 6 Year 19 67	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11		11. IF UNDER 24 HRS. Hours 11 Min. 11			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY LITHUANIA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME SI BALLIN				14. MOTHER'S MAIDEN NAME GERTRUDE LANE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. DAUGHTER			
17. INFORMANT MRS. GERTRUDE ORENSTEIN W. HYATTS, MD.				Address 7409 17th Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery insufficiency DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Known 11 yrs. Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from April 24, 1956 , to January 6, 1967 , that (I) (we) last saw the deceased alive on January 3, 1967 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE Aaron H. Traum M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 6 1967	
22c. PHYSICIAN'S NAME (Type) AARON H. TRAUM MD				22d. ADDRESS 8237 GEORGEA AVE. SILVER SPG. MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-8-67		23c. NAME OF CEMETERY OR CREMATORY BNAI JACOB CEMETERY		23d. LOCATION (City, town or county) (State) CHARLESTON, W. VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS				ADDRESS WASHINGTON, DC		25a. REC'D BY REGISTRAR JAN 9 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00018

00018

STATE OF DEATH

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CHRISTIAN W. HAYES, JR.

ANTHONY

ANTHONY

1-2-57

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ANTHONY

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00919		00919	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>36 hrs. 15 min.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		d. STREET ADDRESS <u>13103 BLUNNILL Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID Joseph Goodman</u> First Middle Last		4. DATE OF DEATH <u>1</u> <u>19</u> <u>67</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-67</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u>15</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>James Goodman</u>		14. MOTHER'S MAIDEN NAME <u>Diane Demerest</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mothers</u>	
17. INFORMANT <u>Mothers</u>		Address <u>As Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Atrial Myocardial Infarction (Coronary Artery Disease)</u> <u>7546</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 17</u> , 19 <u>67</u> , to <u>JAN. 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-19</u> 19 <u>67</u> , and that death occurred at <u>5:30A.M.</u> from causes and on the date stated above.		22a. SIGNATURE <u>McConley</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN R. McCONLEY</u>		22d. ADDRESS <u>3716 Howard Ave. Washington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/23/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REC'D BY REGISTRAR <u>1331 Rockl. Pike Rockville, Md.</u> DATE <u>JAN 24 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00019

CERTIFICATE OF DEATH

00019

Montgomery

30 June 1967

Holy Cross Hosp

Male White

James Goodman

1-17-67

X

Goodman

Montgomery Co., Md. United States
Dinner Democrat

Probable cause of death

11 07

1 12 12

00920

CERTIFICATE OF DEATH

Mrs. Lou Madison Gormurs

00920

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>8310 Donaghue Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lou</u> <u>Madison</u> <u>Gormurs</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>26</u> <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-94</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winston Wooden</u>		14. MOTHER'S MAIDEN NAME <u>Marie Lesurier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records - Washington Sanitarium & Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Symptoms</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>12-16</u> , 19 <u>66</u> , to <u>1-26</u> , 19 <u>67</u> that <u>(1)</u> (we) last saw the deceased alive on <u>1-26</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> P.M., from causes on and on the date stated above.			
22a. SIGNATURE <u>Seruch T. Kimble</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>1-26-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/29/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ardena Wesley Evans</u>	23d. LOCATION (City or Town) (County) (State) <u>Ardena</u> <u>Virginia</u>
24. FUNERAL DIRECTOR <u>Takoma Funeral Home</u>		25a. REC'D BY REGISTRAR <u>254 Carroll St</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>		DATE <u>JAN 30 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03230

STATE OF TEXAS

03230

[Faint, mostly illegible handwritten text, possibly a legal document or affidavit, covering the majority of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00921					00921				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> <u>15.1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11503 Monticello Avenue</u>					d. STREET ADDRESS <u>11503 Monticello Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>May</u> Last <u>Gratton</u>					4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1967</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1897</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. State Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Troy, New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles D. Watson</u>					14. MOTHER'S MAIDEN NAME <u>Mary (unknown)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Joseph Gratton</u> Address <u>11503 Monticello Avenue Wheaton, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1965</u> , to <u>Jan 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 14, 1967</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>John J. Curry M.D.</u>					22b. DATE SIGNED <u>1/14/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>					22d. ADDRESS <u>10620 Georgia Avenue</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>			23b. DATE THEREOF <u>January 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Jean the Baptist Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Troy, New York</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					DATE <u>JAN 17 1967</u>				

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STATE OF TEXAS

County of _____
City of _____
I, _____, County Clerk of said County, do hereby certify that _____
is the owner of _____
and that the same is subject to a lien in favor of _____
for the sum of _____ Dollars.

Witness my hand and the seal of said County at _____
this _____ day of _____, 19____.

County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00922					00922					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>					
c. LENGTH OF STAY IN MD <u>4 yrs 3 mo 6 days</u>					d. STREET ADDRESS <u>11524 - GEORGIA AVE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NRSg HOME 2101 FAIRLAND RD</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>GREENHOUSE</u> Last <u>GREENHOUSE</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>19</u> Year <u>1967</u>							
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1986</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>SAUL RUBIN</u>					14. MOTHER'S MAIDEN NAME <u>GOLDIE ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>			16. SOCIAL SECURITY NO. <u>220-14-9921</u>		17. INFORMANT Address <u>WHEATON, MD.</u> <u>LEON GREENHOUSE 11524 - GA. AVE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypochromic anemia, Chronic Pyelonephritis & nephrosis</u>										
19. INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>years</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>65</u> , to <u>1-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-18</u> , 19 <u>67</u> , and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>John R Spencer</u>					22b. DATE SIGNED <u>1-19-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN R SPENCER</u>					22d. ADDRESS <u>15444 - COLUMBIA RD, BERTONSVILLE MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>1-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MONTI FIORE CEM.</u>			23d. LOCATION (City, town or county) (State) <u>LONG ISLAND, N.Y.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>B DANZANSKY & SONS 351-14th NW</u>					25a. REC'D BY REGISTRAR <u>DATA 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>			

00322

CERTIFICATE OF DEATH

00322

First Name

John

Last Name

Robinson

Place of Birth

1124 Georgia Ave

Home Address

1124 Georgia Ave

241 Robin

1124 Georgia Ave

Place of Death

1124 Georgia Ave

Place of Burial

1124 Georgia Ave

Signature

1124 Georgia Ave

Date

11-22-1918

John E. Spencer

1124 Georgia Ave

John E. Spencer

1124 Georgia Ave

John E. Spencer

1124 Georgia Ave

00923

CERTIFICATE OF DEATH

00923

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9105 WOODLAND DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>SILVER SPRING MD</u>	
3. NAME OF DECEASED (Type or print) <u>LEE ROSE</u> First Middle Last <u>GREENSTONE</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/4/97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAURICE OSIN</u>		14. MOTHER'S MAIDEN NAME <u>DESSIE WINTHROP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-50-9188</u>	
17. INFORMANT <u>IRVING GREENSTONE SAME AS 21</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Hypertensive - Arteriosclerotic Cardiovascular</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>67</u> , to <u>1-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-15</u> 19 <u>67</u> , and that death occurred at <u>5⁴⁵</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas P. Fogarty</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u>		22d. ADDRESS <u>1011 UNIVERSITY BLVD EAST SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-17-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ONEV SHOLOM CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON DC</u>
24. FUNERAL DIRECTOR <u>Healey Funeral Home</u> ADDRESS <u>4217 9th St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK

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STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

STATE OF NEW YORK

00924

CERTIFICATE OF DEATH

00924

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 2 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 151		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Congressional Manor N. H.				d. STREET ADDRESS 6712 Fairfax Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE E. GREGORY				4. DATE OF DEATH Month Day Year January 7 1967			
5. SEX female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1887		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dental technician		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? u s a	
13. FATHER'S NAME Charles				14. MOTHER'S MAIDEN NAME Anna Waters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 176 10 8737		17. INFORMANT Martha H. Johnson Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct , 19 63 , to 1-6- , 19 67 , that (I) (we) last saw the deceased alive on 1-5 19 67 , and that death occurred at 11 M, from causes and on the date stated above.							
22a. SIGNATURE Paul D Cantor				22b. DATE SIGNED 1/6/67		22c. PHYSICIAN'S NAME (Type) Paul D Cantor	
22d. ADDRESS 4709 Montgomery Ave Bethesda, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/9/1967		23c. NAME OF CEMETERY OR CREMATORY St. Marks,		23d. LOCATION (City or Town) (County) (State) PETERSVILLE, MD.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC., WASH., D.C.				25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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35237

00925

CERTIFICATE OF DEATH

00925

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		<u>15-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Patomac Manor Nursing Home</u>			d. STREET ADDRESS <u>7100 Brookville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>H. W.</u> Last <u>GRIFFIN</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>1967</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 24 1888</u>	9. AGE (In years lost birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during <u>last</u> working life, even if retired) <u>DECORATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housing</u>	11. BIRTHPLACE (County & State, or foreign country) <u>WASH, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILTON GRIFFIN</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH SMITH</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-183230</u>	17. INFORMANT <u>Louise Fallon</u> Address <u>13505 Keating St. Rockville, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Carcinoma</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>1-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-1</u> 19 <u>67</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>D. L. Bucy</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. L. Bucy</u>			22d. ADDRESS <u>809 Veins Mill Rd Rockville</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 6</u> 1967	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00926

CERTIFICATE OF DEATH

00926

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY New Jersey c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delair d. STREET ADDRESS 8436 Stow Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Christina Middle Etta Last GROVER		4. DATE OF DEATH Month January Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1964
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Guantanamo Bay, Cuba
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clark A. Grover	
14. MOTHER'S MAIDEN NAME Theresa Pelchat		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A	
16. SOCIAL SECURITY NO. 		17. INFORMANT Address New Jersey Clark A. Grover, 8436 Stow Road, Delair	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis left pulmonary artery DUE TO (b) Transposition of great vessels with ventricular septal defect and pulmonary stenosis DUE TO (c) Congenital malformation, heart			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that it (this hospital) attended the deceased from Jan. 4 , 19 67 to Jan. 12 , 19 67 that it (we) last saw the deceased alive on Jan. 12 , 19 67 , and that death occurred at 240A AM, from causes and on the date stated above.			
22a. SIGNATURE Donald H. Gaylor		22b. DATE SIGNED Jan. 12, 1967	
22c. PHYSICIAN'S NAME (Type) Donald H. Gaylor, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 1-13-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Prince George County, Md.
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		25a. REC'D BY REGISTRAR JAN 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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D. M. Anderson, M. D. Bunker

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00927

00927

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1 d. STREET ADDRESS <u>5323 Pooks Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Josephine Donaghy</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. OATE OF DEATH <u>Jan.</u> Month Day Year <u>15</u> <u>1967</u> 9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>Michael J. Donaghy</u> 14. MOTHER'S MAIDEN NAME <u>Margaret McCarthy</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>084-10-8118</u> 17. INFORMANT <u>Husband - Walter - Same</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8 Acute Broncho pneumonia</u> DUE TO (b) <u>Metastatic Carcinoma</u> OUE TO (c) <u>Adenocarcinoma, Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>45h</u> <u>18 mo</u> <u>19 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 1964 to <u>Jan 14</u> , 1967, that (I) (we) lost saw the deceased alive on <u>Jan 14</u> 1967, and that death occurred at <u>15:27 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. Killay</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>Jan 15 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. Killay</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. OATE THEREOF <u>1-19-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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00928

CERTIFICATE OF DEATH

00928

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 23 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9307 Cedar Lane 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DeReba Middle L. Last Gustin				4. DATE OF DEATH Month January Day 13 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1907	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 13 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph McKibben				14. MOTHER'S MAIDEN NAME Frances Shaw			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-58-5639		17. INFORMANT Richard M. Gustin-husband-same item # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 581.1 Caennec's Cirrhosis of liver - 2 years IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypothyroidism							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 19 65 , to January 12 , 19 67 , that (I) (we) last saw the deceased alive on January 12 , 19 67 , and that death occurred at 2:25 P.M. from causes and on the date stated above.							
22a. SIGNATURE Lewis Ned Cahill				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/13/67	
22c. PHYSICIAN'S NAME (Type) LEWIS NED CAHILL, M.D.				22d. ADDRESS 5411 Cedar La., Suite 201-A Bethesda, Maryland 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/67		23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill		23d. LOCATION (City or Town) (County) (State) Perrysville, Pa.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				25a. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C. 20250
OFFICE OF THE ASSISTANT SECRETARY
FOR PLANT INDUSTRY
WASHINGTON, D. C. 20250

00929

CERTIFICATE OF DEATH

00929

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

68
Cleared with Medical Examiner -

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN lb 0		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring				d. STREET ADDRESS 1511 Madison Street	
3. NAME OF DECEASED (Type or print) Walter		First Haines		Last Hanley Sr.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/98		9. AGE (In years last birthday) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) New York City, NY	
13. FATHER'S NAME Wm. Hanley			14. MOTHER'S MAIDEN NAME Ada Minshull		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 066-07-6422		17. INFORMANT Walter Hanley, Jr. Son	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) ACUTE POSTERIOR MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 46 YEARS					INTERVAL BETWEEN ONSET AND DEATH 46 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) EMPHYSEMA					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1/22, 1967 , to 1/29, 1967 , that (I) (we) last saw the deceased alive on 1/21, 1967 , and that death occurred at 8:00 AM , from causes and on the date stated above.					
22a. SIGNATURE Henry R. Wolfe		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/29/67	
22c. PHYSICIAN'S NAME (Type) Henry R. Wolfe		22d. ADDRESS 905-Sheridan St. Hyattsville Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/1/67		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	
23d. LOCATION (City or Town) Arlington, Va.		(County)		(State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR FEB 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

05200

CS200

Dr. Regs notified & approved.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00930

CERTIFICATE OF DEATH

00930

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>6 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cloverly</i> <i>15.1</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Randolph Hills Nursing Home</i>		d. STREET ADDRESS <i>15.1</i>	
3. NAME OF DECEASED (Type or print) <i>SUSIE</i> First <i>Catherine</i> Middle <i>HARDING</i> Last		4. DATE OF DEATH Month <i>Jan</i> Day <i>18</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 23, 1878</i>
9. AGE (In years last birthday) <i>88</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Ednor, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>William P. Leizear</i>	
14. MOTHER'S MAIDEN NAME <i>Ida Jane Brown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> <i>None</i>	
16. SOCIAL SECURITY NO. <i>215-14-7032-A</i>		17. INFORMANT <i>Mrs. Eva Wadford</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes mellitus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July, 1966</i> to <i>1-18, 1967</i> , and that (I) (we) last saw the deceased alive on <i>1-18, 1967</i> , and that death occurred at <i>6:52 P.M.</i> from causes and on the date stated above.		22. DATE SIGNED <i>1-18-67</i>	
22a. SIGNATURE <i>George F. Sengstack M.D.</i>		22b. PHYSICIAN'S NAME (Type) <i>George F. Sengstack, M.D.</i>	
22c. ADDRESS <i>9241 Columbia Blvd., S. S., Md.</i>		22d. REC'D BY REGISTRAR <i>JAN 23 1967</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 21, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Burtonsville Union Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Burtonsville, Maryland</i>	
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>		25. REGISTRAR'S SIGNATURE <i>J. Charles J.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

00931

CERTIFICATE OF DEATH

00931

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> XXXXXXXXXX 15		d. STREET ADDRESS <u>2527 Glenallen Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>Helen</u> Last <u>HARTSOCK</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-07</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Cty. Public Schools</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME XXXXXXXXXX <u>Edward Patrick Duffy</u>	
14. MOTHER'S MAIDEN NAME <u>Brigitte A. Haney</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>228-03-7647</u>		17. INFORMANT <u>John M. Hartsock</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pat neurotic disorder</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic Hepatitis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> , 19 <u>67</u> , to <u>Jan 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> , 19 <u>67</u> , and that death occurred at <u>5:00</u> A.M. from causes and on the date stated above.	
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Jan 28, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>8641 Colesville Rd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 31, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pamphrey, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>	

00831

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00932

CERTIFICATE OF DEATH

00933

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>2 YEARS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		d. STREET ADDRESS <u>6820 Kerley Pl.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SYLVAN MAYOR NURSING Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Alonza</u> Last <u>HAYES</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sales Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>	11. BIRTH PLACE (County & State, or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alonza Jacoby</u>	
14. MOTHER'S MAIDEN NAME <u>Callie Berry</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>	
16. SOCIAL SECURITY NO. <u>577017080</u>		17. INFORMANT <u>John W Hayes</u> Address <u>SAME as D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 433.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arrhythmia Heart</u> (c) <u>Branchiopneumonia - Pyrexia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 9, 1967</u> to <u>Jan 16, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 13, 1967</u> and that death occurred at <u>9:35 M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.		22b. DATE SIGNED <u>Jan 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>11,000 OLD GEORGETOWN RD. ROCKVILLE, MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithland md</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300-4 St N.E.D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

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FOR STATE
HEALTH DEPT.

00933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00932

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washingtonian Motel, Rt. 705,		d. STREET ADDRESS 3143 "O" ST., N.W.	
3. NAME OF DECEASED (Type or print) FRANK EBERHART HAYNES, JR.		4. DATE OF DEATH Month JANUARY Day 19 Year 1967	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 MAY 1931
9. AGE (In years last birthday) 36 35 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. MARINE CORPS	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRANK EBERHART HAYNES		14. MOTHER'S MAIDEN NAME FRANCES LARNER GORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 4 Jun54 - Pres		16. SOCIAL SECURITY NO. 577 38 7594	
17. INFORMANT (wife)		Address Mrs. Cecilia K. W. Haynes, Richmond, VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate intoxication DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took overdose of Seconal and Amytal intentionally	
20c. TIME OF INJURY Month, Day, Year Hour am Jan 19 1967 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washingtonian Motel-Gaithersburg Montg.Md.	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 1/22/67	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED	
Address (Street, city, town, or county) Montgomery			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 1/23/1967	23c. NAME OF BURIAL OR CREMATORY Fort Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.
24. FUNERAL DIRECTOR W. W. Chambers Co., 1400 Chapin St., N.W.		25. REC'D BY REGISTRAR JAN 25 1967	
ADDRESS Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEPARTMENT OF COMMERCE

DEPARTMENT OF COMMERCE

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John R. Ball

WASHINGTON, D.C.

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WASHINGTON, D.C.

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WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00934

00934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN lb <u>43 hours & 45 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16-2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>6208 20th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Brett</u> Last <u>Hearn</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-12</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rutherford Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Clara Brewington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>408 106232</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary failure, + old infarction</u> DUE TO (b) <u>Critical arrhythmia</u> DUE TO (c) <u>Polythrombosis and Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>slow</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12:00 am, 1967</u> , to <u>1:26 p.m., 1967</u> , that (I) (we) last saw the deceased alive on <u>1/25/1967</u> , and that death occurred at <u>1:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>(Signature)</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H W. Lottin</u>				22d. ADDRESS <u>7600 Carroll Ave Tak Pk Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Jan 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem. Park</u>		23d. LOCATION (City or town) (County) (State) <u>Hyattsville Tenn</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

000333

CERTIFICATE OF DEATH

000334

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, CITY OF NEW YORK, AND A COPY OF IT IS TO BE FURNISHED TO THE FUNERAL HOME OR OTHER PERSON IN CHARGE OF THE BURIAL OF THE DECEASED.

00935

CERTIFICATE OF DEATH

00935

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>		c. LENGTH OF STAY IN lb <u>25 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Alger Heflin</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John William Carter Heflin</u>		14. MOTHER'S MAIDEN NAME <u>Maude V. Norford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-07-4330</u>	
17. INFORMANT <u>John B. Heflin</u>		Address <u>Poolesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5 Jan</u> , 19 <u>67</u> , to <u>16 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5 Jan</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Gordon Murdock Smith</u>		22b. DATE SIGNED <u>16 Jan 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon Murdock Smith, M.D.</u>		22d. ADDRESS <u>Barnesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leesburg Union Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Leesburg, Va.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or offending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2009

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

00936

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00936

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in lb <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. + Hospital</u>				d. STREET ADDRESS <u>1034 Univ. Blvd. E</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Benjamin Helman</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-0363</u>	9. AGE (In years last birthday) yrs. <u>33</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Equip Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Ashtola, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey Helman</u>				14. MOTHER'S MAIDEN NAME <u>Elva Penrod</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>211-07-3190</u>		17. INFORMANT <u>Sarah E. Helman (wife)</u> Address <u>1034 Univ. Blvd. S.S. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary artery heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) _____					22. DATE SIGNED <u>JAN. 10, 1967</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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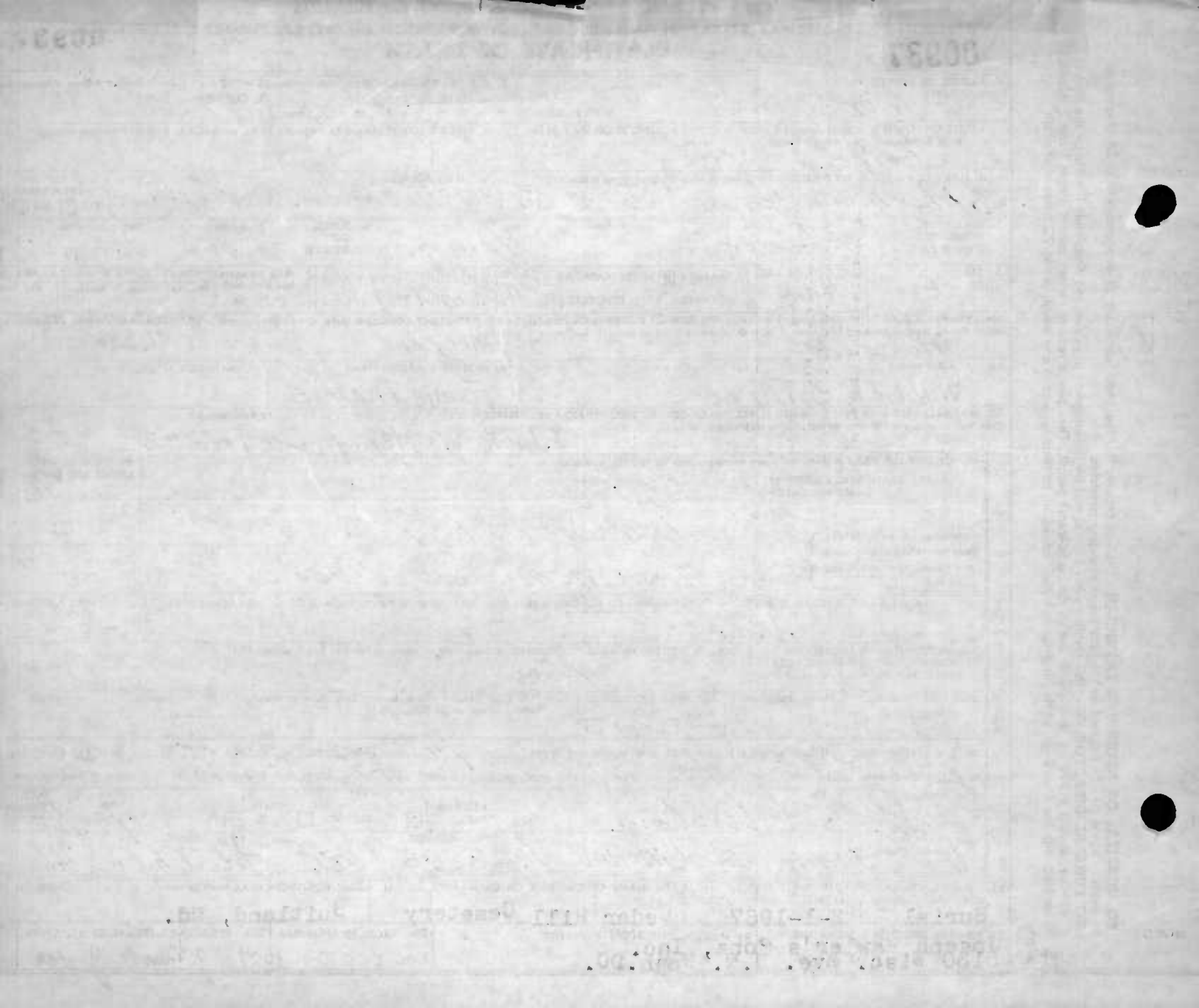
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00937

00937

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>3359-42nd Pl. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Eleanor</u> First <u>Henry</u> Middle Last				4. DATE OF DEATH <u>Jan - 30 - 1967</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 25, 1897</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William R. B. Turner</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If available or dates of service)		17. INFORMANT Address <u>Jack W. Henry - See Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma of liver</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1/4</u> , 19 <u>67</u> , to <u>present</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>67</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John B. Umhau</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU MD</u>				22d. ADDRESS <u>8805 Conn. Ave. Ch. Ch. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR <u>FEB 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00938

CERTIFICATE OF DEATH

00938

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Prince William Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b Woodbridge (Rural) 83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 415 E. St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Doris Middle (NMN) Last HICKS		4. DATE OF DEATH Month January Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1925
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas G. Martin		14. MOTHER'S MAIDEN NAME Della O'Dell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 228 28 1272	
17. INFORMANT James W. Hicks		Address 415 "E" ST., Woodbridge, Va	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST, WITH WIDESPREAD METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec 30 , 19 66 , to Jan 1 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 1 , 19 67 , and that death occurred at 4:00PM , from causes and on the date stated above.			
22a. SIGNATURE H. E. Ashworth		22b. DATE SIGNED January 2, 1967	
22c. PHYSICIAN'S NAME (Type) H. E. Ashworth, LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 Jan. 67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR B. Earl Mountcastle Cunningham Mountcastle		25a. REC'D BY REGISTRAR JAN 4 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Journal of Management Education 30(6)

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00939

CERTIFICATE OF DEATH

00939

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>15.1</u>	
c. LENGTH OF STAY IN 1b <u>3 hours</u>		d. STREET ADDRESS <u>4410 Woodfield RD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUTH (NMO) Hinkson</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-04</u>
9. AGE (in years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mont. Co. Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Henry County, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank A. Hinkson</u>		14. MOTHER'S MAIDEN NAME <u>Lillian C. Becker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Miss Charlotte L. Davis</u>		Address <u>501 S. Walnut, Mt. Rainier, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Infarct, myocardial, massive</u> DUE TO (b) <u>Thrombosis, of coronary artery</u> DUE TO (c) <u>Arteriosclerosis, coronary, severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , to <u>Jan. 1, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 1, 1967</u> , and that death occurred at <u>3:22</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Harold Heigcs</u>		22b. DATE SIGNED <u>1/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold Heigcs</u>		22d. ADDRESS <u>1835 1 ST. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Enid City Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Enid, Oklahoma</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00024

00940

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Nash. Sc.</i> b. COUNTY <i>17.3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jakoma Park</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington San & Hosp.</i>		d. STREET ADDRESS <i>1390 Nicholson St NW</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Morris</i> Middle <i>none</i> Last <i>Hirsch</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>27</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 15, 1875</i>
9. AGE (In years lost birthday) <i>91</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
11. BIRTHPLACE (County & State, or foreign country) <i>Rumania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Cisher A. Hirsch</i>		14. MOTHER'S MAIDEN NAME <i>Leah Hirsch</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hosp. Record</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral thrombosis</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>yes</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>JAN. 21</i> , 19 <i>67</i> , to <i>JAN. 27</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>JAN. 26</i> , 19 <i>67</i> , and that death occurred at <i>9:30</i> A.M., from causes and on the date stated above			
22a. SIGNATURE <i>Albert H. Grollman</i> M.D.		22b. DATE SIGNED <i>1/27/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALBERT H. GROLLMAN</i>		22d. ADDRESS <i>1106 SPRING ST. SILVER SPRING MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1/27/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>King David Mem. Gar.</i>	23d. LOCATION (City or Town) (County) (State) <i>Falls Ch., Virginia</i>
24. FUNERAL DIRECTOR <i>Bernard Danzansky and Sons</i>		25a. REC'D BY REGISTRAR <i>JAN 30 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

00340

00340

1/27/67

Central American
Bimonthly

Jan 21 1967

Jan 21 1967

Albert H. Grochman

1/27/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00941

00941

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Falls Church</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5000 but 6 am</u>		d. STREET ADDRESS <u>7316-Lee Highway</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Douglas Hood</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk Condor</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Franklin Hood</u>		14. MOTHER'S MAIDEN NAME <u>Loretta Neely</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes Army Korea</u>		17. INFORMANT Address <u>James Marie Hood 102 Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries - Severe</u> DUE TO (b) <u>Trauma from Auto-Accident</u> DUE TO (c) <u>819.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>33 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of car + struck bridge abutment</u>	
20c. TIME OF INJURY Month, Day, Year <u>1.5</u> Hour <u>am</u> <u>Jan 7</u> <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 4-495</u>	20f. (City or town). (County) (State) <u>Bethesda</u> <u>Montgomery Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>Jan. 8, 1967</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Falls Ch. Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington</u> <u>Virginia</u>
24. FUNERAL DIRECTOR <u>Pearson's Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00942											
00942											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>4mo 7day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Unity</u> <u>15.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belmont Nursing Home</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura E. Howard</u>						4. DATE OF DEATH Month Day Year <u>Jan 9 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/29/1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Gaithersburg, Mont</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>William Berkeley</u>						14. MOTHER'S MAIDEN NAME <u>Virginia Degg</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-12-7767</u>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct,</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V Disease</u>											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> to <u>1/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>67</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>C. H. Ligon</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/9/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. H. Ligon</u>						22d. ADDRESS <u>SANDY SPRING, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>BURIAL</u>		<u>Jan. 13, 1967</u>		<u>Howard Cemetery</u>		<u>Unity, Md</u>					
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>						ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
						DATE <u>JAN 16 1967</u>					

00345

00345

Howard E. Howard

2/22/1962
U.S. District Court
District of Columbia

Donald E. Howard
U.S. District Court
District of Columbia

1/1/62

Robert F. Howard
U.S. District Court
District of Columbia

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00943

00943

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN it <u>6 months</u>		d. STREET ADDRESS <u>904 Daleview Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>904 Daleview Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cecil LOVE HURLEY</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-08</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Atty. Investigator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. AGRIC.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Uel L. Hurley</u>		14. MOTHER'S MAIDEN NAME <u>Willie Belle Watts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-34-2581</u>	
17. INFORMANT <u>Kay B. Hurley</u>		Address <u>904 Daleview Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to</u> DUE TO (b) <u>Hanging, self-inflicted</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased hanged self in basement of home</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:00 a.m. 1-27 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Silver Spring Montg Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>1-27-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		Address (Street, city, town, or county) <u>4400 W. 1st St. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>Jan 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Oklahoma City, Oklahoma</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
Address <u>Warner L. Pumphrey, Inc. Silver Spring, Md.</u>		DATE <u>FEB 1 1967</u>	

00843

RECEIVED - DEPARTMENT OF JUSTICE

00843

1964 JUN 11

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter body.]

[Illegible text, possibly a signature block or additional correspondence details.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Item 23d Film G384 1/12/67 mh

00944

CERTIFICATE OF DEATH

00944

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5302 Waneta Road</u>		d. STREET ADDRESS <u>5302 Waneta Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>R</u> Last <u>Jacobs</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 16, 1888</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Confectioner</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Hazleton, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John Henry Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Clara Baur</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>202-01-1398</u>	
17. INFORMANT <u>Daug. Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, secondary to perforation of ileum, attached to abdominal wall by post operative adhesions</u> DUE TO (b) <u>Peritonitis, secondary to perforation of ileum, attached to abdominal wall by post operative adhesions</u> DUE TO (c) <u>Peritonitis, secondary to perforation of ileum, attached to abdominal wall by post operative adhesions</u>	
19. INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Abdominal Aortic Aneurysm</u>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u>19</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> , 19 <u>66</u> , to <u>1/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>66</u> , and that death occurred at <u>12/27</u> , 19 <u>66</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. S. Brennan</u>		22b. DATE SIGNED <u>1/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. S. BRENNAN</u>		22d. ADDRESS <u>Cherry Chase, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 1-3-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>West Hazleton, Penna.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>H.O. Butts</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 9 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00945					00945						
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15.1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS Hospital</u>					d. STREET ADDRESS <u>1536 Red Oak Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILMER</u> Middle <u>Aubrey</u> Last <u>JASPER</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>24</u> Year <u>1967</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/28/04</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Associate FENCE Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FENCE Co.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Woodson J. Jasper</u>					14. MOTHER'S MAIDEN NAME <u>Mary S. McDonald</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>WW11 579-01-3102</u>		17. INFORMANT <u>Andrew Jasper</u>		Address <u>1536 Red Oak Drive Silver Spring, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of prostate</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>67</u> to <u>1/24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>67</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph Bloom</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/25/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Joseph Bloom</u>					22d. ADDRESS <u>1015 Spring St., Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

2500

2320

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00946

CERTIFICATE OF DEATH

00947

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>319 Lincoln Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Preston</u> First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-06-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>66</u> yrs.
13. FATHER'S NAME <u>Asbury Johnson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louise Johnson - wife - SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X cerebral hemorrhage</u> DUE TO (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>9</u> <u>1 yr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5 Jan</u> , 19 <u>67</u> , to <u>14 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 Jan</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>SEAR J. DAVIN</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SEAR J. DAVIN</u>		22d. ADDRESS <u>4977 Brattle Lane Bethesda</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 17 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1580

20200

00947

CERTIFICATE OF DEATH

00946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		d. STREET ADDRESS <u>5425 Conn. Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>A</u> Last <u>JOHNSTON</u>		4. DATE OF DEATH <u>JANUARY 20</u> 19 <u>67</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE (In years last birthday) <u>77</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Julius B. Aveilhe</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Carroll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-28-0926</u>	
17. INFORMANT <u>Anita A. Davis</u>		Address <u>5425 Conn. Ave. N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tuberculous Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/1/67</u> , 19 <u>66</u> to <u>1/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/19/67</u> , 19 <u>67</u> , and that death occurred at <u>1:07 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>E. Stuart Lyddane</u>		22b. DATE SIGNED <u>1/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane</u>		22d. ADDRESS <u>3066 Q St. N.W., Washington D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Fairfax County, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wis. Ave. N.W.</u>		DATE <u>JAN 26 1967</u>	
Washington, D.C.			

00240

CERTIFICATE OF DEATH

00240

M

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
						</																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00948					00948				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Montgomery			a. STATE		b. COUNTY		
		MARYLAND					District of Columbia		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Gaithersburg					Washington				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?	
Asbury Methodist Home for the Aged, Inc.					1921 Kalorama Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
		Edward		Howard		Jones		Month Day Year	
								January 22 19 67.	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 13, 1872		94 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Real Estate				Prince William County, Va.			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
George B. Jones					Flora Andrews				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
unknown		220-44-5662		Asbury Methodist Home, Gaithersburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								491X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DUE TO	
								(b)	
								DUE TO	
								(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?	
Generalized arteriosclerosis								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 12/22/67, 19 to 1/22/67, 19, that (I) (we) last saw the deceased alive on 1/23/67, 19, and that death occurred at 4:30 PM, from the causes and on the date stated above.									
22a. SIGNATURE						22b. DATE SIGNED			
Dr. Henry C. Scruggs						1/22/67			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		1-24-67		Rock Creek		Washington, D. C.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ernest C. Gartner						JAN 25 1967		Charles Judge	
Gaithersburg, Md.						DATE			

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Handwritten notes and signatures, including "General" and "1/25/67".

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00949

00949

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>5</u> days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> P.G. ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> 16.2 d. STREET ADDRESS <u>8504 14th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. William</u> First Middle Last <u>Howard</u> <u>Jones</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>18</u> <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-20 24</u>
9. AGE (In years lost birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptor Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District Lithograph Co. Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. America</u>	
13. FATHER'S NAME <u>Charles E. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Griebel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>43-46</u>		16. SOCIAL SECURITY NO. <u>679-26-8150</u>	
17. INFORMANT <u>Mary J. Jones</u> <u>Adelphi, Md.</u>		18. ADDRESS <u>8504 14th Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>190.9</u> IMMEDIATE CAUSE (a) <u>Malignant Melanoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> , 19 <u>66</u> , to <u>18 Jan</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>17 Jan</u> 19 <u>67</u> and that death occurred at <u>2:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Monica P. Fagarty</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Monica P. Fagarty</u>		22d. ADDRESS <u>1015 W. Blvd E. Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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DECEASED

DATE OF DEATH

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00950

00950

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Court House Square Apt. 101</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First Middle Last		4. DATE OF DEATH <u>Jan. 31</u> 19 <u>67</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/98</u> 9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Mont.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin H. Karpis</u>		14. MOTHER'S MAIDEN NAME <u>Annie Laura Sudrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. W. R. Turner</u>		Address <u>4715 Essington Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and congestion</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic constrictive pericarditis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Burns 20 legs with gangrene and amputation, right leg</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bed clothes caught fire when smoking in bed.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:30 p.m. 1/6 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>Nursing Home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Rockville Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Ball</u> M.D.		22. DATE SIGNED <u>Feb. 1, 1967.</u>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>2/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 3 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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For the purpose of the present investigation

it is necessary to determine the

relative importance of the

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John W. B. C.

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CERTIFICATE OF DEATH

00951

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN b. 2-3/4 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Derwood d. STREET ADDRESS 19709 Muncaster Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAROLD PAUL KELLY, SR. First Middle Last				4. DATE OF DEATH Jan. 17 1967 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/96	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor - Retired				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State, or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Patrick H. Kelly				14. MOTHER'S MAIDEN NAME Catherine Barry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 217-52-6501		17. INFORMANT Address Hospital Records, Olney, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause } (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intermittent Heart Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/17/67 to 1/17/67 , that (I) (we) last saw the deceased alive on 1/17/67 , and that death occurred at 6:15P , from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Ligon				22b. DATE SIGNED 1/17/67			
22c. PHYSICIAN'S NAME (Type) Charles H. Ligon				22d. ADDRESS Medical Center, Olney, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-20-1967		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Inc.				25a. REC'D BY REGISTRAR JAN 20 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1200

222

FOR STATE
HEALTH DEPT

00952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00952

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md	c. LENGTH OF STAY IN lb 2 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital, Silver SpMd		d. STREET ADDRESS 10713 Shaftsbury St	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOHN First Richmond Middle Last Kenner		4. DATE OF DEATH Month January Day 8 Year 19 67	
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-17
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country)- S. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Chick Kenner	
14. MOTHER'S MAIDEN NAME Sally Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr Wyatt Kenner Address 3916 muffed st Kensington, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary occlusion, left Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO posteroseptal region (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) JAN. 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Rockwell	23d. LOCATION (City or Town) (County) (State) Templeton, S.C.
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockwell	
So. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED IN LIAISON UNIT - JAN 2/57

FOR STATE
HEALTH DEPT.

00953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00953

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b. <u>1 hr 10 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>THOMAS</u> Last <u>KING</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15 - 1905</u>
9. AGE (In years last birthday) yrs. <u>61</u>		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Hauling</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William King</u>		14. MOTHER'S MAIDEN NAME <u>Bertie Copeland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>7223 MUNCASTER</u>	
17. INFORMANT <u>Ada King</u> WIFE Address <u>MILLYRD. 7223 MUNCASTER</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John L. Ball</u> M.D.		22. DATE SIGNED <u>1/17/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Jan. 23, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove</u>		23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Montg, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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00253

UNITED STATES DEPARTMENT OF AGRICULTURE

00253

General Inspector
C. H. K. K. K. K. K.

John H. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00954

CERTIFICATE OF DEATH

00954

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. LENGTH OF STAY IN lb <u>2 mo. 26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DA MASCUS</u> <u>151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC VALLEY Nursing Home</u>			d. STREET ADDRESS <u>25631 Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Pomona</u> Middle <u>B.</u> Last <u>King</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>1</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1894</u>		9. AGE (In years lost birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY, MARYLAND</u>	
13. FATHER'S NAME <u>Lincoln Bordette</u>			14. MOTHER'S MAIDEN NAME <u>Ellen King</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>James T. King</u> Address <u>326 Woodfield Rd Damascus Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno. carcinoma</u> DUE TO <u>Sigmoid Colon + Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>metastases</u> (c)					INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio-Vascular Bone System</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1962, to <u>Jan 1</u> , 1967, that (I) (we) last saw the deceased alive on <u>12/1/67</u> 19 <u>67</u> , and that death occurred at <u>3:26</u> A.M. from causes and on the date stated above.					
22a. SIGNATURE <u>M. McKendree Boyer</u>		22b. DATE SIGNED <u>Jan 1, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>M. McKendree Boyer M.D.</u>	
22d. ADDRESS <u>9701 Church St</u>		<u>Damascus Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Meth.</u>	23d. LOCATION (City or Town) (County) (State) <u>Clarksburg, Md.</u>		
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>JAN 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2800

2200

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00955

00955

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8329 Draper Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Ford Kistle</u>		4. DATE OF DEATH <u>January 19 1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 18, 1893</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Josiah Kistle</u>		14. MOTHER'S MAIDEN NAME <u>Emma Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>473-09-9295</u>		17. INFORMANT <u>Emily B. Kistle</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>		DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>JAN. 20, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Shell Lake, Wisconsin</u>		22a. LOCATION (City, town, or country) (State)	
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22c. DATE THEREOF <u>Jan. 25, 1967</u>		22d. NAME OF CEMETERY OR CREMATORY <u>Shell Lake Cemetery</u>		22e. ADDRESS <u>Shell Lake, Wisconsin</u>	
23. FUNERAL DIRECTOR <u>John B. Thomas</u>		23a. REC'D BY REGISTRAR <u>Charles Judge</u>		23b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 26 1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6320

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 6 hrs 35 min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS 722 4-Mile Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Allen Last KLEMM		4. DATE OF DEATH Month January Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1967
9. AGE (In years last birthday) yrs. 6		IF UNDER 1 YEAR Months 6 Days 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Bethesda, Montgomery, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank L. Klemm, Jr.		14. MOTHER'S MAIDEN NAME Margaret Ann Senyo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Newton Falls Address Ohio Frank L. Klemm, Jr., 402 Arlington Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO (b) 7600 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) 7600			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Jan. 11 , 19 67 , to Jan. 11 , 19 67 that he (we) last saw the deceased alive on Jan. 11 , 19 67 , and that death occurred at 735AM , from causes and on the date stated above.			
22a. SIGNATURE Jerry J. Tomasovic M.D.		22b. DATE SIGNED 13 Jan. 1967	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-16-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR JAN 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00957

CERTIFICATE OF DEATH

00957

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN lb 6 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Washington		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home		d. STREET ADDRESS Nebraska Ave. N.W. 11901 Georgia Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Kline		4. DATE OF DEATH Month Jan. Day 18, Year 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1877
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John W. Thompson		14. MOTHER'S MAIDEN NAME Lunetta F. St. John	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sister Mrs. Dorothy Thompson		Address Washington, DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis DUE TO Arteriosclerosis, very advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, mild		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1946 , to Jan 18, 1967 , that (I) (we) last saw the deceased alive on Jan 16, 1967 , and that death occurred at 4:30 p.m. from causes on and on the date stated above.			
22a. SIGNATURE Stewart Clapp		22b. DATE SIGNED 1-18-1967	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp M.D.		22d. ADDRESS 4740 Chevy Chase Dr. Chevy Chase 15 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-21-67	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JAN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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NAME		DATE	
ADDRESS		CITY	
STATE		ZIP	
TELEPHONE		FAX	
E-MAIL		WEB	
OCCUPATION		EDUCATION	
EMPLOYER		EMPLOYMENT TYPE	
REASON FOR REQUEST		TESTS REQUESTED	
SPECIAL INSTRUCTIONS		SPECIAL HANDLING	
SPECIAL DELIVERY		SPECIAL STORAGE	
SPECIAL PACKAGING		SPECIAL LABELING	
SPECIAL SHIPPING		SPECIAL TRACKING	
SPECIAL INSURANCE		SPECIAL LIABILITY	
SPECIAL SIGNATURE		SPECIAL STAMP	
SPECIAL NOTES		SPECIAL COMMENTS	

RECEIVED - LABORATORY OF PHYSICS, NATIONAL BUREAU OF STANDARDS, WASHINGTON, D.C. 20540

CERTIFICATE OF DEATH

00958

00958

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 30 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON JAN., & HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 409 Southwest Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE First Roswell Middle KNIGHT Last		4. DATE OF DEATH JANUARY 17 Month 17 Day 1967 Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/05
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Eng.		10b. KIND OF BUSINESS OR INDUSTRY "NOL"	
11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BARRETT KNIGHT		14. MOTHER'S MAIDEN NAME MARY HELDRUM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Harriette B. Knight Address (Same as # 2)		18. Harriette B. Knight (above)	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 340.3 IMMEDIATE CAUSE (a) Stroke Arterios Cause uncertain DUE TO Cholecystitis & unsuccessful operation DUE TO Congestive failure & renal insufficiency DUE TO fracture PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) fracture			INTERVAL BETWEEN ONSET AND DEATH weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/10/1967 to 1/17/1967 , that (I) (we) lost saw the deceased alive on 1/17/1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Chas H. Wolohin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Chas H. Wolohin		22d. ADDRESS 831 Univ Blvd E Silver Sp	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR Glen Carter ADDRESS 8434 Georgia Ave		25a. REC'D BY REGISTRAR JAN 24 1967	
Warner E. Pumphrey, Inc.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00828

00222

Exhibits - manuscript
Exhibits - manuscript

11/17/27 10/10/28 11/17/27

Chas H. Wolcott

Jan. 21, 1927 date of house
Silver Spring, Maryland

CERTIFICATE OF DEATH

00959

00959

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN TB <u>5 1/2 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>626 Bennington Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mr. William (nmn) Knowles</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>67</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-87</u>		9. AGE (In years last birthday) <u>79</u> Yrs.	10. IF UNDER 1 YEAR Months <u>27</u> Days <u>19</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phelps Dodge Refining Corp. England</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Knowles</u>				14. MOTHER'S MAIDEN NAME <u>Mary Greenhaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>453-03-9637-A</u>		17. INFORMANT <u>Gertrude Knowles</u> Address <u>626 Bennington Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Myocardial Infarction</u> DUE TO (b) <u>Post op Prostectomy</u> DUE TO (c) <u>Carcinoma of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>177X</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/23</u> , 19 <u>67</u> , to <u>1/27</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>12:01 PM 1/27/67</u> and that death occurred at <u>1:06 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Bloom</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Bloom</u>				22d. ADDRESS <u>1015 Spring St., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 30, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>E. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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ESTIMATE OF DEATH

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Name of deceased		Date of death	
Place of death		Cause of death	
Age at death		Sex	
Occupation		Marital status	
Education		Religion	
Social status		Family size	
Previous illness		Mental health	
Alcohol consumption		Drug use	
Smoking habits		Other habits	
Family history		Genetic factors	
Environmental factors		Social support	
Medical history		Treatment received	
Mental health history		Mental health treatment	
Substance use history		Substance use treatment	
Trauma history		Trauma treatment	
Other relevant information		Other relevant information	

FOR STATE
HEALTH DEPT.

00960

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00960

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Dist. of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47.3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 933 "N" St., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last William HENRY KNOX JR.		4. DATE OF DEATH Month Day Year January 14, 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab.	9. AGE (In years) yrs. 44 Months Days Min.
11. BIRTHPLACE (State or foreign country) Phila., PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. H. Knox, Sr.		14. MOTHER'S MAIDEN NAME FLORENCE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 197-18-5763	
17. INFORMANT Ruth T. Knox		Address 6644 Boyer St., Phila.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries with 816.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) exsanguination incurred in auto-motorcycle collision DUE TO (c) collision			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased thrown from auto in collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:15 p.m. 1-14 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Hyattsville Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED JAN. 14, 1967		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-20-67	23b. DATE THEREOF 1-20-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, V.H.
24. FUNERAL DIRECTOR Arlington Phillips		25a. REC'D BY REGISTRAR DATE JAN 20 1967	
Address 1727 N. Monroe St.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00961

CERTIFICATE OF DEATH

00961

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5636 Western Ave.		MARYLAND c. LENGTH OF STAY IN 1b — e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 5636 Western Ave	
3. NAME OF DECEASED (Type or print) Jules Gilmer Körner Jr.		First Jules		Middle Gilmer	
Last Körner Jr.		4. DATE OF DEATH Jan. 11 1967		Month Jan.	
Day 11		Year 1967		9. AGE (In years last birthday) 78 yrs.	
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 24, 1888		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Kernersville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jules Gilmer Körner	
14. MOTHER'S MAIDEN NAME Polly Alice Masten		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 215-38-3206	
17. INFORMANT Jules G. Körner III		Address Chevy Chase, Md.		3302 Rolling Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Chronic Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 5 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1 , 19 66 , to Jan. 11 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 9 , 19 67 , and that death occurred at 2 P.M. from causes and on the date stated above.		22a. SIGNATURE Clifton R. Gruver		22b. DATE SIGNED 1/11/67	
22c. PHYSICIAN'S NAME (Type) Clifton R. Gruver		22d. ADDRESS 915 19th St NW, Wash. DC		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/67		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery	
23d. LOCATION (City or Town) (County) (State) Kernersville, N.C.		24. FUNERAL DIRECTOR Joseph Gawlers Sons		25a. REC'D BY REGISTRAR JAN 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE JAN 20 1967		25d. ADDRESS 5130 Wisc. Ave Wash. D.C.	

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY H-OWARD					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRINKLOW			c. LENGTH OF STAY IN 1b D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRINKLOW					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT #650					d. STREET ADDRESS RT#650			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DENNIS KOSH					4. DATE OF DEATH JAN. 6 1967					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6, 1885		9. AGE (In years last birthday) 81		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Kosh					14. MOTHER'S MAIDEN NAME Rachel Tyler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address: Whelan Station OFFICER EMIL A. LEJNAR, MTGMY CTY. POLICE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute myocardial thrombosis with infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22. DATE SIGNED										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-10-67		23c. NAME OF CEMETERY OR CREMATORY Sandy Spring.		23d. LOCATION (City or Town) (County) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR Robert L. Sunden					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or entombment, and in any event, within 72 hours after death.

VR A15 (4)
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00963

CERTIFICATE OF DEATH

00963

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>2110 Prichard Road</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret ELIZABETH Harmon Koziol</u>		4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N. Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William Corrigan</u>	
14. MOTHER'S MAIDEN NAME <u>Delia Burke</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>577-12-6131</u>		17. INFORMANT <u>John Stanley Koziol</u> <u>2110 Prichard Road Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma breast (pulmonary edema)</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma breast with metastases</u> DUE TO <u>2 years</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/66</u> , 19 <u>66</u> , to <u>1/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/5/67</u> 19 <u>67</u> , and that death occurred at <u>6:40 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Patrick C. Jameson</u> M.D.		22b. DATE SIGNED <u>1/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson</u>		22d. ADDRESS <u>117186a Ave Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>John S. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>JAN 11 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00964					00964				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> c. LENGTH OF STAY IN 1b <u>3 yrs. 6 mo. 8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>740 E. 49th St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Krause</u> Middle Last 4. DATE OF DEATH <u>January 11</u> Month <u>11</u> Day <u>1967</u> Year			5. SEX <u>Female</u> 6. COLOR OR RACE <u>Hebrew</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JAN 25, 1888</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MEYER BUCHALTER</u>					14. MOTHER'S MAIDEN NAME <u>MIRIAM HABER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Solomon Schoenberg</u> Address <u>740 E. 49th St. Brooklyn, N.Y.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>SHOCK & SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DECUBITAL ULCERS</u> (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 mo</u> <u>3 + yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10 Jan 1967</u> , to <u>Jan 11, 1967</u> that (I) (we) last saw the deceased alive on <u>10 Jan 1967</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ira N. Tublin</u>					22b. DATE SIGNED <u>11 Jan 67</u>			22c. PHYSICIAN'S NAME (Type) <u>Ira N. Tublin, M. D.</u>	
22d. ADDRESS <u>800 PERSHING DRIVE S.S.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1-12-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mr. Hebron Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>FRESHING, L.I., N.Y.</u>		
24. FUNERAL DIRECTOR <u>Soldberg Funeral Home</u>			ADDRESS <u>4217-9th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>D.O.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
			DATE <u>JAN 16 1967</u>						

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2004.5.20

James R. ...

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00965

CERTIFICATE OF DEATH

00965

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 122 Chinlee Drive	
3. NAME OF DECEASED (Type or print) First Eddie Middle Lee Last LAMB, Jr.		4. DATE OF DEATH Month January Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1966
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 18 Hours 2 Min. 18.2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eddie L. Lamb, Sr.		14. MOTHER'S MAIDEN NAME Margaret Felderman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mr. Eddie L. Lamb, Sr., 122 Chinlee Drive		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventriculitis due to E. coli DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if) (this hospital) attended the deceased from Dec. 30, 1966 to Jan. 17, 1967 , that (if) (we) last saw the deceased alive on Jan. 17, 1967 , and that death occurred at 746 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>P. B. Blanchard</i>		22b. DATE SIGNED Jan. 18, 1967	
22c. PHYSICIAN'S NAME (Type) P. B. BLANCHARD, LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-21-67	23c. NAME OF CEMETERY OR CREMATORY Pleasant View	23d. LOCATION (City or Town) (County) (State) Kewanee, Illinois
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		25a. REC'D BY REGISTRAR JAN 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23800

5200

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00966

CERTIFICATE OF DEATH

00966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>4402 44th St. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elsie S. Lamb</u>		4. DATE OF DEATH <u>1-14-1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Schenken</u>		14. MOTHER'S MAIDEN NAME <u>Elsie A. Hannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-32-1511</u>	
17. INFORMANT <u>John Lamb - Husband</u>		Address <u>SAME ITEM 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Cerebral Artery Aneurysm, left</u> 330X DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 13</u> , 19 <u>67</u> to <u>Jan 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 14</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>George Sharpe</u>		22b. DATE SIGNED <u>1-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. George Sharpe, 10511</u>		22d. ADDRESS <u>Summit Ave., Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-17-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wisc. Ave. N.W., Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JAN 20 1967</u>			

4200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00967 CERTIFICATE OF DEATH					00967					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>			15.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>2703 Munson Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Joseph LaMontain</u>					4. DATE OF DEATH Month Day Year <u>January 28 1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/10/22</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>44</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEDICAL TECH.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NIH</u>		11. BIRTH PLACE (County & State, or foreign country) <u>NEW YORK</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>ALBERT LA MONTAIN</u>					14. MOTHER'S MAIDEN NAME <u>Esther Elmina Patnock</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>084-18-0040</u>		17. INFORMANT Address <u>Ermine C. LaMontain - Home # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> , 19 <u>66</u> , to <u>1-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>66</u> , and that death occurred at <u>8:37 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>John A. Reisinger</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-29-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>John A. Reisinger</u>					22d. ADDRESS <u>1835 I Street, N.W. Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md. Montg.</u>				
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>					ADDRESS <u>1331 Rock. Pike</u>		25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10916

00968

CERTIFICATE OF DEATH

00968

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN 1b <i>4 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i> d. STREET ADDRESS <i>115 Meem Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Ann</i> Last <i>Lane</i>		4. DATE OF DEATH Month <i>1</i> Day <i>21</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/14/1880</i>
9. AGE (In years last birthday) yrs. <i>86</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>21</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Prince Georges Co. VA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Joseph Bate Lane</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Griffith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>326-72-4061</i>	
17. INFORMANT <i>Mary R. Riddolph</i>		Address <i>1513 Chestnut Place Bethesda, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Encephalomalacia, left</i> DUE TO (b) <i>Cerebral thrombosis</i> DUE TO (c) <i>Cerebral arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i> <i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Concurrent lobular pneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/18</i> , 19 <i>67</i> , to <i>1/21</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1/21</i> , 19 <i>67</i> , and that death occurred at <i>8:45</i> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>L. I. Leal</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Luciano I. Leal</i>		22d. ADDRESS <i>Gaithersburg Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>Jan. 25, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Blandford Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Petersburg, Virginia</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		25a. REC'D BY REGISTRAR <i>BETHESDA, MARYLAND</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>JAN 27 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

00969

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00969

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8500 16th Street, Apt. 422		d. STREET ADDRESS 8500 16th Street, Apt. 422	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle L. Last LEGAULT		4. DATE OF DEATH (Found) Month January Day 17 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1919
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leo Paul Legault		14. MOTHER'S MAIDEN NAME Emma Sauve	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1946		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Dr. Oscar Legault		Address Md. 5501 Surrey Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of pancreas DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 157X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 1/18/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) XXXX-Burial-1-23-1976	23b. DATE THEREOF 1-23-1976	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		ADDRESS N.W. Wash. D.C.	
25a. REC'D BY REGISTRAR JAN 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF AGRICULTURE

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[Faint, illegible text and markings covering the page]

Case reported to Dr. Reap - Coroner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00970					00970				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>151</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>304 East Franklin Avenue</u>					d. STREET ADDRESS <u>304 East Franklin Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chauncey Cornelius Lentz</u>					4. DATE OF DEATH Month Day Year <u>January 23 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 23, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Evening Star</u>		11. BIRTHPLACE (County & State, or foreign country) <u>York County, Penna.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deitrich Lentz</u>					14. MOTHER'S MAIDEN NAME <u>Adeline Shaffer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary B. Lentz</u>		Address <u>304 East Franklin Avenue Silver Spring, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of cecum and ascending colon (removed)</u>									INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u> </u> to <u>January 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 12 1967</u> , and that death occurred at <u>9:40</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 23, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr. M.D.</u>					22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Maryland</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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2000-2001-2002-2003

304 (282) 106-6

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2010-11-10

2002, 2003, 2004, 2005

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9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film G305 1/24/67 mh

00971

CERTIFICATE OF DEATH

00971

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>47.3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>5402 8th ST N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BARBARA ROSS LEWIS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/15/92</u>
9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MINNESOTA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MINNESOTA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN CAMERON</u>		14. MOTHER'S MAIDEN NAME <u>AGNES BELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS (2) C.V. ACCIDENT (3) PARKINSON'S DISEASE</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>18 Jan.</u> , 19 <u>60</u> , to <u>11 Jan.</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>10 Jan.</u> , 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel T. Kimble</u>		22b. DATE SIGNED <u>11 Jan '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S.T. KIMBLE</u>		22d. ADDRESS <u>927 Pershing Drive Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 14. 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Walter Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 16 1967</u>	

17500

RECEIVED

17500



00972

CERTIFICATE OF DEATH

01106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with medical examiner

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 15.1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 200 Randolph Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RACHEL		First RACHEL		Middle Lewis		Last Lewis		4. DATE OF DEATH Jan. 6 19 67		Month Jan.		Day 6		Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/91		9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Austria-Hungaria				12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Schrager						14. MOTHER'S MAIDEN NAME Unknown													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Morris Lewis				Address 200 Randolph Rd. Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Coronary arrest DUE TO (b) congestive heart failure DUE TO (c) arteriosclerotic heart disease												INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) diabetes mellitus												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from June 1960 , to June 6, 1967 , that (I) (we) last saw the deceased alive on 1/6 1967 , and that death occurred at 10 P.M. from causes and on the date stated above.																			
22a. SIGNATURE [Signature]												22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) 18 F Kreuzburg												22d. ADDRESS 7852 16th Ave Wash DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-8-67				23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery				23d. LOCATION (City or Town) (County) (State) Maspeth, L.I., N.Y.							
24. FUNERAL DIRECTOR GOLDBERG FUNERAL HOME								ADDRESS 4217-9th ST. N.W.				25a. REC'D BY REGISTRAR JAN 9 1967				25b. REGISTRAR'S SIGNATURE [Signature]			

3678

5500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00973					00972						
1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>HOWARD.</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>			c. LENGTH OF STAY IN 1b <i>17 DAYS</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>DAYTON</i>			13.2			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>FAIRLAND NURSING HOME</i>					d. STREET ADDRESS <i>Linthicum Rd.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>THOMAS HOWARD LINTHICUM</i>			4. DATE OF DEATH Month Day Year <i>1 24 1967</i>								
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-1-1887</i>		9. AGE (in years last birthday) <i>79</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>HOWARD-Co. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John J. LINTHICUM</i>					14. MOTHER'S MAIDEN NAME <i>MARGARET CLARK</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16. SOCIAL SECURITY NO. <i>217-32-9974-81</i>		17. INFORMANT Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA of Left Atrium</i> <i>1602</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>with metastases</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 10, 1967</i> to <i>Jan 24, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan 19, 1967</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Boris Rabkin</i>			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Jan 24, 1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN, MD</i>			22d. ADDRESS <i>1019 Unit Blvd, EGT</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1-27-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Providence</i>		23d. LOCATION (City, town or county) (State) <i>Glenelg, Md</i>				
24. FUNERAL DIRECTOR <i>F.C. Higinbotham</i>					25a. REC'D BY REGISTRAR DATE <i>JAN 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

2220

CERTIFICATE OF DEATH

00974

00973

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. STREET ADDRESS <u>13766 NOTLEY RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13766 NOTLEY RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Blanche M. Linton</u>				4. DATE OF DEATH <u>JAN 9 1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1910</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DESIGNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FLORIST</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES M. LINTON</u>				14. MOTHER'S MAIDEN NAME <u>AMY LAYMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-20-6325</u>		17. INFORMANT <u>Edward Linton</u> <u>13766 Notley Rd Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Adenocarcinoma of Pancreas</u> <u>157X</u> <u>with metastasis</u> Conditions, if any, which gave rise to immediate cause (b) <u>DUE TO</u> (e), stating the underlying cause last. <u>DUE TO</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>about 9-10 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>28 Dec 1966</u> to <u>23 Jan 1967</u> that (I) (we) last saw the deceased alive on <u>28 Dec 1966</u> , and that death occurred <u>4:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Lund</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. Lund</u>				22d. ADDRESS <u>4438 AM</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LINTON CHAPEL CEM</u>		23d. LOCATION (City, town or county) (State) <u>CLARKSVILLE MD.</u>			
24. BURIAL DIRECTOR'S SIGNATURE <u>Hugh D. Linton</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>JAN 12 1967</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should retain page 4 and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal.

000273

000274

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00975

CERTIFICATE OF DEATH

00974

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)		c. LENGTH OF STAY IN lb 3 hrs 15 min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 5709 Denfield Road	
3. NAME OF DECEASED (Type or print) Patrick Theodore LOMAN		4. DATE OF DEATH Month 29 Day January Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1965
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	9. AGE (In years last birthday) yrs. 1
11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Loman		14. MOTHER'S MAIDEN NAME Rae Ann Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Rockville		Address Maryland HMC John W. Loman, USN, 5709 Denfield Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7511 IMMEDIATE CAUSE (a) MENINGOMYELOCELE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 29 , 19 67 , to Jan. 29 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan 29 , 1967, and that death occurred at 1030PM , from causes and on the date stated above.			
22a. SIGNATURE T E Kelly		22b. DATE SIGNED Jan. 31. 1967	
22c. PHYSICIAN'S NAME (Type) T. E. KELLY, LT, MC, USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-1-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home		25a. REC'D BY REGISTRAR DATE FEB 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00037

00037

RECEIVED
JAN 10 1967
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF PUBLIC HEALTH
WASHINGTON, D.C. 20495

TO: DIRECTOR, BUREAU OF PUBLIC HEALTH
FROM: [illegible]
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00976

CERTIFICATE OF DEATH

00975

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <u>Montgomery</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>Box 64</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John W Lowman</u>		4. DATE OF DEATH Month Day Year <u>January 24 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/76</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Lowman</u>		14. MOTHER'S MAIDEN NAME <u>Amy Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis-Genl.</u> DUE TO <u>Kidney</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Prostatic Hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>67</u> , to <u>1-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> , 19 <u>67</u> , and that death occurred at <u>11:30 A.M.</u> on <u>1-24</u> , 19 <u>67</u> , and on the date stated above.			
22a. SIGNATURE <u>Jack Schumacher</u> M.D.		22b. DATE SIGNED <u>1-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M.D.</u>		22d. ADDRESS <u>Russell Avenue, Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick County, Va.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR <u>Rayton</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 27 1967</u>	

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* * * 70-12002 (27-12-86)

Classified Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

(M)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
00977					CERTIFICATE OF DEATH					00976				
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>					d. STREET ADDRESS <u>3333 University Blvd. W.</u>									
3. NAME OF DECEASED (Type or print) <u>Bert Le Roy MacDonald</u>					4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1967</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer Power Company</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>Duncan MacDonald</u>					14. MOTHER'S MAIDEN NAME <u>Emma Wilson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W. II</u>			16. SOCIAL SECURITY NO. <u>577-05-0444</u>		17. INFORMANT <u>Daughter, Marie Sheets</u>			Address <u>9305 Alcona S Lanham, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Thrombosis</u> DUE TO <u> </u> (c) <u>Coronary Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>Indef</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Auto. Mollities & C.H.T.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/67</u> , 19 <u>67</u> , to <u>1/20/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/1/67</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.														
22a. SIGNATURE <u>Stephen Jones</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/20/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>Stephen Jones</u>					22d. ADDRESS <u>Rockville, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>							
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JAN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00978 CERTIFICATE OF DEATH 00977									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1000 DALEVIEW DR. SILVER SPRING, MD c. LENGTH OF STAY IN 1b 2 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ALTHEA WOODLAND NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY P.G. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capital Heights d. STREET ADDRESS 16-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First ISABELLE Middle JONES Last MANSFIELD			4. DATE OF DEATH Month JAN. Day 16 Year 1967						
5. SEX FE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) QUEEN ANNE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME DARUS JONES					14. MOTHER'S MAIDEN NAME CECILLE SCOTT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO.		17. INFORMANT JOHN MANSFIELD		Address P.O. BOX 8469 CAPITOL HEIGHTS, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 1. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis with cholelithiasis								INTERVAL BETWEEN ONSET AND DEATH 3 months years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1967 , to Jan 16, 1967 , that (I) (we) last saw the deceased alive on Jan 16, 1967 , and that death occurred at 12:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Philip E. Jones					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/16/67
22c. PHYSICIAN'S NAME (Type) P. E. JONES, M.D.					22d. ADDRESS 800 PERSHING DR. SILVER SPRING, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 19		23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE		23d. LOCATION (City, town or county) (State) STEVENSVILLE MD.			
24. FUNERAL DIRECTOR Edgar L. Lane Church Hill, Md.					ADDRESS		25a. REC'D BY REGISTRAR JAN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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00979

CERTIFICATE OF DEATH

00978

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp.</u>			d. STREET ADDRESS <u>504 Domer Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>DAISY Ruth Martin</u>			4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-96</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chisman, Ill.</u>	
13. FATHER'S NAME <u>CLARENCE SCHANCE</u>			12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Harold Arthur Martin - 504 Domer Ave</u> <u>Chisman</u> <u>Takoma Park, Maryland</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIAC DECOMPENSATION</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 DAYS</u> <u>3 DAYS</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/12/65</u> to <u>1/5/67</u> , that (I) (we) last saw the deceased alive on <u>1/3/67</u> , and that death occurred at <u>9:35 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Howard T Morse</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/5/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>C. Glen Carter</u> <u>48434 Georgia Ave. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 11 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00378

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00980

CERTIFICATE OF DEATH

00979

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in lb <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DC</u>		47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN & HOSP</u>				d. STREET ADDRESS <u>110 MARYLAND AVE, NE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILNDR</u> Middle <u>WHITTINGTON</u> Last <u>MARTIN</u>				4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-94</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MEMBER OF CONGRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Martin</u>				14. MOTHER'S MAIDEN NAME <u>LAURA GRAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>609X Acute bacterial endocarditis - Congestive</u> DUE TO (b) <u>Septicemia</u> DUE TO (c) <u>Urinary tract infection</u> and arrhythmia							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinson's disease, Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>66</u> to <u>1-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-1</u> , 19 <u>67</u> , and that death occurred at <u>10⁰⁰ PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>B.G. Bendler MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.G. Bendler M.D.</u>				22d. ADDRESS <u>10820 GA. Ave Wheaton, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-4-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Hill CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u>				ADDRESS <u>300 42ND ST NE WASH. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

00330

00330

STATE OF CALIFORNIA

OFFICE OF THE ATTORNEY GENERAL
JULY 1, 1900

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00981

00980

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		d. STREET ADDRESS <u>7480 Blair Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Ralston Fletcher Mathews</u>		4. DATE OF DEATH <u>1</u> Month <u>27</u> Day <u>1967</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-14</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralston Mathews</u>		14. MOTHER'S MAIDEN NAME <u>Lucy (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ralston C. Mathews</u>		Address <u>-7480 Blair Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple, Extreme</u> DUE TO (b) <u>Injuries with Exsanguination due to</u> DUE TO (c) <u>being run over by train.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Deceased sat down between rails in front of oncoming train.</u>	
20c. TIME OF DEATH <u>6:30</u> Month, Day, Year <u>1-27</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, lot, street, office bldg., etc.) <u>RR. Track</u>	20f. (City or town) <u>Takoma Park</u> (County) <u>Montgom.</u> (State) <u>Ind.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>1-27-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street, City, Town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>John T. Stewart, Jr.</u>		25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00982 CERTIFICATE OF DEATH 00981

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bella Vista Nursing Home 571 Univ. Blvd. East		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9003 Garland Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma J. Mathewson		4. DATE OF DEATH Month January Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT. 26, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY TELEPHONE	9. AGE (in years last birthday) 80 yrs.
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS T. RALEY		14. MOTHER'S MAIDEN NAME LAURA ANN STINEHOMER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-09-1657	
17. INFORMANT JOSIE M. CORAKAS		Address 571 Univ. Blvd. East S.E. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Uremia DUE TO Arteriosclerotic Gangrene (b) Generalized Arteriosclerotic Heart Disease (c) 5 yrs			INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 wk's 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 130 , to 1/30 , 19 67 , that (I) (we) last saw the deceased alive on 1/27 , 19 67 , and that death occurred at 4A M, from the causes and on the date stated above.			
22a. SIGNATURE James H. Keizer		22b. DATE SIGNED 1/30/67	
22c. PHYSICIAN'S NAME (Type) Ha		22d. ADDRESS 1835 Eye St NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 FEB. 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME		25a. REC'D BY REGISTRAR WASH D.C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 2 1967	

48200

32100

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

yes, no

00983

CERTIFICATE OF DEATH

00982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY in lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>1120 DENNIS CT.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANCE</u> Middle <u>A.</u> Last <u>MAVER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>♂</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/91</u>		9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>67</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles H. Hurdle</u>				14. MOTHER'S MAIDEN NAME <u>Kathrine Hines</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Charles Mayer</u> <u>1110 Dennis Ct.</u> <u>Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Massive)</u> 331X DUE TO <u>Cerebral Arteriosclerosis</u> Undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arterial Hypertension</u> Undetermined (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr - 48</u> , 19 <u>66</u> , to <u>Jan 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 11</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u>				22b. DATE SIGNED <u>Jan 12, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>	
22d. ADDRESS <u>Silver Spring, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>10620 66th Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

00883

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00984

CERTIFICATE OF DEATH

00983

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 27 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Arlington		83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) POTOMAC VALLEY NURSING HOME 1235 POTOMAC VALLEY RD		d. STREET ADDRESS 4310 12th Road, S.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MAE Bond MAYNARD		4. DATE OF DEATH Month Day Year JANUARY 15 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31/1886
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) NEWARK, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE BOND		14. MOTHER'S MAIDEN NAME BERTHA REBECCA FLAMMER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 212-162 710	
17. INFORMANT H. E. Maynard		Address 112104 Devilwood Dr. Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 153m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 Jan 1967 to 16 Jan 1967 , that (I) (we) last saw the deceased alive on 6 Jan 1967 , and that death occurred at 11:30 A.M. from causes and on the date stated above			
22a. SIGNATURE Wm. S. Murphy		22b. DATE SIGNED 15 Jan 67	
22c. PHYSICIAN'S NAME (Type) Wm. S. Murphy		22d. ADDRESS 615 Montgomery Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR 8434 Georgia Ave. Silver Spring, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 20 1967	

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UNITED STATES OF AMERICA

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WASHINGTON, D.C.

4310 12th Street, N.W.

NAVY

U.S. Navy

U.S. Navy

12104 Boulevard
Washington, D.C.

Mr. S. E. Raymond

Home

Home

Mr. S. E. Raymond

Mr. S. E. Raymond

Washington, D.C.

Mr. S. E. Raymond

Mr. S. E. Raymond

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #2a,b,c, & d fill in #0384 1/16/67 pc

00985

CERTIFICATE OF DEATH

00984

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NW 11401 11411 Washington</u>		47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hosp</u>				d. STREET ADDRESS <u>1123 Michigan Ave. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josie Belle</u> Middle <u>Beth</u> Last <u>Metz</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-23-87</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Wash. DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Enoch Metz</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Snyder</u>				15. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>466X Pulmonary Embolism</u> DUE TO <u>Iliac thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>4-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia; Acute Gastric Dilatation; Coronary Atherosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Jan 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 8</u> , 19 <u>67</u> , and that death occurred at <u>530 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Whitlock</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH WHITLOCK</u>				22d. ADDRESS <u>7717 Carroll Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Pr. Geo. Co., Md</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Inc</u>				25a. REC'D BY REGISTRAR <u>8655 88 Ave Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00282

00282

UNITED STATES OF AMERICA	
DEPARTMENT OF THE ARMY	
OFFICE OF THE CHIEF OF STAFF	
WASHINGTON, D. C.	
1. NAME (Last, First, Middle Initial)	
2. GRADE OR RATE	
3. BRANCH	
4. SERVICE NUMBER	
5. DATE OF BIRTH	
6. DATE OF ENTRY INTO SERVICE	
7. DATE OF EXPIRATION OF SERVICE	
8. DATE OF DEATH	
9. DATE OF INTERVIEW	
10. DATE OF REVIEW	
11. DATE OF RE-EVALUATION	
12. DATE OF RE-EVALUATION	
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99. DATE OF RE-EVALUATION	
100. DATE OF RE-EVALUATION	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00986

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00985

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>J</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>DOA</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> <u>RD # 2</u> <u>75.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>Ro. Box 216</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>EMORY</u> Last <u>MILEY</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 14 - 1914</u>
9. AGE (In years last birthday) yrs. <u>52</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Engrg</u>	
11. BIRTHPLACE (State or foreign country) <u>Quincy - PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Miley</u>		14. MOTHER'S MAIDEN NAME <u>Effie Walford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES Second World War</u>		16. SOCIAL SECURITY NO. <u>204-01-5356</u>	
17. INFORMANT (Sister) Address <u>EDNA MILEY</u> <u>WAYNESBORO RD #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 - Myocardial Infarction - Acute -</u> DUE TO (b) <u>Coronary Occlusion.</u> DUE TO (c) <u>Cardio Vascular Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>24h.</u> <u>Years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>1/9/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Quincy</u>		23d. LOCATION (City or Town) (County) (State) <u>Quincy Franklin Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter V. Grove,</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Waynesboro Pa.</u>		DATE <u>JAN 12 1967</u>	

00885

00885

00885

00885-1-105

John G. Bell

1/12/67

Quincy

Quincy

00987

CERTIFICATE OF DEATH

00986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>6 yr 10 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Congressional Manor Sanitarium</u>				d. STREET ADDRESS <u>4121 Aspen St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>S.</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-1872</u>		
				9. AGE (In years last birthday) <u>94</u> yrs.		10. UNDER 1 YEAR Months <u>17</u> Days <u>19</u> Hours <u>67</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Smith Chew</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Harrison Coffin</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Col. A.M. Miller - See Item No. 2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Atherosclerosis, generalized + cerebral</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>47</u> , to <u>Jan 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 17</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> P.M. from causes and on the date stated above.								
22a. SIGNATURE <u>Charles W. O'Drman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-18-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. O'DRMAN</u>				22d. ADDRESS <u>1712 EYE ST. NW - WASH DC</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>1-19-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Point Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>West Point, N.Y.</u>		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00880

ACCOUNT OF DEATH

00887

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		CERTIFICATE	
						</																			

00988

CERTIFICATE OF DEATH

00987

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>55 hrs/45 min</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				151			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>7908 Flower Ave. Apt. #4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Pedersen Miller</u>				4. DATE OF DEATH Month Day Year <u>January 14, 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1907</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Miller</u>				14. MOTHER'S MAIDEN NAME <u>Ann Marie Pedersen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-435</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>with congestive failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cardiac Arrhythmia - 2 Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Jan 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> , 19 <u>67</u> , and that death occurred at <u>3:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James J. [Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James J. [Signature]</u>				22d. ADDRESS <u>7717 Canwell Ave Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/18/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Danvers Massachusetts</u>	
24. FUNERAL DIRECTOR <u>Arthur Waters</u>				ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20012</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>JAN 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18200

CERTIFICATE OF MARRIAGE

18200

Blank certificate form with horizontal lines for text entry.

Cleared with Dr. Reaps for signing of Certificate by Dr. Wolohan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

00989

CERTIFICATE OF DEATH

00988

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN b. <u>2 hr. 20 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>515 Margaret Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALTON</u> First <u>CARL</u> Middle <u>MILLS</u> Last		DATE OF DEATH <u>11</u> / <u>7</u> / <u>1967</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lucien Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Pettit</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>216-44-9254</u>	
17. INFORMANT <u>Marion Mills - wife</u> Address: <u>15 Margaret Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4901</u> <u>Acute Myocardial Infarction Inferior</u> DUE TO <u>Coronary fibrillation & disorganized rhythm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>W. S. H. D. & Congestive failure</u> DUE TO <u>Cause of A.S.H.D. - Hypertension</u> (c) <u>4-5 hrs</u> <u>4-5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>67</u> , to <u>11/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-3 mo ago</u> 19 <u>67</u> , and that death occurred at <u>7:58 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Chas H. Wolohan</u>		22b. DATE SIGNED <u>1-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H. Wolohan</u>		22d. ADDRESS <u>831 University Blvd. E., S. S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u> DATE <u>JAN 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2800

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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(I)

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00990						00989					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY			Montgomery			a. STATE			Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Gaithersburg			b. COUNTY					
c. LENGTH OF STAY IN 1b			MARYLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Asbury Methodist Home for the Aged, Inc.						3801 Frederick Ave.			30.4		
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
			Nannie			Emma			Mitchell		
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH		
F			W						July 29, 1883		
9. AGE (In years last birthday)			10. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
83 yrs.						Baltimore, Md.			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John C. Taylor						Cordelia J. Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						17. INFORMANT Address					
No						216-09-4452 Asbury Methodist Home, Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis											
332X DUE TO Cerebral Arteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized Arteriosclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction											
19. INTERVAL BETWEEN ONSET AND DEATH 9 DAYS											
20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 4/25/63, 19....., to 1/11/67, 19....., that (I) (we) last saw the deceased alive on 1/10/67, 19....., and that death occurred at 5:50 AM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED			1/11/67		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			M.D.		
22a. SIGNATURE						22d. ADDRESS			M.D.		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
23b. DATE THEREOF 1/14/67											
23c. NAME OF CEMETERY OR CREMATORY											
London Park Cemetery Baltimore, Md.											
23d. LOCATION (City, town or county) (State)											
Baltimore, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE											
Wm. J. Fisher											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
JAN 12 1967											

00290

California

Agency, authorized name for the Agency, Inc.

3601 Frederick Ave.

July 22, 1933

U. S. Govt. Clerk

Baltimore, Md.

John C. Taylor

Cordeiro, J. Smith

210-02-1422 Agency, authorized name, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00991

CERTIFICATE OF DEATH

00990

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Ohio b. COUNTY Columbus	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 9 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbus 72-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 1070 Trentwood Road	
3. NAME OF DECEASED (Type or print) First Donna Middle Louise Last MOORE		4. DATE OF DEATH Month January Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1939
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Columbus, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert A. Moore		14. MOTHER'S MAIDEN NAME Mary Kimble	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Columbus Address Ohio Mr. Robert A. Moore, 1070 Trentwood Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Massive bilateral bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hodgkins Disease		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 27 , 19 66 , to Jan. 5 , 19 67 , that (X) (we) lost saw the deceased alive on Jan. 5 19 67 , and that death occurred at 328 P.M. from causes and on the date stated above.			
22a. SIGNATURE E. Perlin, M. D.		22b. DATE SIGNED Jan. 6, 1967	
22c. PHYSICIAN'S NAME (Type) E. Perlin, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-7-67		23b. DATE THEREOF 1-7-67	
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Columbus, Ohio	
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR JAN 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00992

CERTIFICATE OF DEATH

00991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium</u>				d. STREET ADDRESS <u>7110 Exeter Road, Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Moriarty</u>				4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/82</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor-Tel.Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Maurice Timothy Moriarty</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lucy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Sister</u> <u>Teresa Moriarty</u> Address <u>Same as Item 2.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>170X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypoproteinemia sec. to Inanition sec. to</u> DUE TO (c) <u>Metastatic disease, sec. to Breast Cancer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 mos</u> <u>7 or 8 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>59</u> , to <u>1/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/4</u> 19 <u>67</u> , and that death occurred at <u>5:10AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Habeb Bacchus M. D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Habeb Bacchus, M. D.</u>				22d. ADDRESS <u>730-24th Street, N. W., Wash., D. C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 1-7-67</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Worcester, Mass.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DEPARTMENT OF DEATH

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CERTIFICATE OF DEATH

00992

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,	
c. LENGTH OF STAY IN 1b 36 days		d. STREET ADDRESS 1303 Nicholson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patrick James Moriarty		4. DATE OF DEATH Month Day Year January 10, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 August 1961
9. AGE (In years last birthday) yrs. 5		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Moriarty		14. MOTHER'S MAIDEN NAME Ann J. Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address 20014 The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 204.3 IMMEDIATE CAUSE (a) Pseudomonas Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Lymphocytic Leukemia DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 12 Days 2 1/2 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from December 5, 19 66 to January 10, 19 67 that he (we) last saw the deceased alive on Jan. 10, 19 67 , and that death occurred at 4:10 P. from causes and on the date stated above.			
22a. SIGNATURE Roland T. Skeel, M.D.		22b. DATE SIGNED 11 January 1967	
22c. PHYSICIAN'S NAME (Type) Roland T. Skeel, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/13/1967	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND
24. FUNERAL DIRECTOR ADDRESS HYSOING'S FUNERAL HOME-1300 N ST., N.W. WASH.D.C.		25a. REC'D BY REGISTRAR JAN 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb. <u>15.1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San. & Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7501 Palmer Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Sarah Ellen Mosley</u>			4. DATE OF DEATH <u>1 11 1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-66</u> <u>3 wks</u> yrs.		9. AGE (In years last birthday) <u>11</u> Months <u>11</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Takoma Pk., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry D. Mosley</u>					14. MOTHER'S MAIDEN NAME <u>Eden Jones</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father - Harry D. Mosley</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>754.2</u> IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure due to congenital</u> DUE TO (b) <u>heart disease (Interventricular Septal Defect,</u> DUE TO (c) <u>Patent Foramen Ovale, and Patent Ductus Arteriosus)</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		22. DATE SIGNED <u>Jan. 12, 1967</u>							
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Jan. 12, 1967</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woods's Corner Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Penn.</u>			
24. FUNERAL DIRECTOR <u>Arthur Waters</u> ADDRESS <u>254 Carroll St. N.W.</u>				25a. REC'D BY REGISTRAR <u>20</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 16 1967</u>	

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CERTIFICATE OF DEATH

00993

00994

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		
c. LENGTH OF STAY IN 1b <i>6 years</i>			d. STREET ADDRESS <i>10415 Fawcett St #106</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>10415 Fawcett Street</i>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Minna</i> First <i>Muhlhausen</i> Middle Last			4. DATE OF DEATH <i>Jan. 30</i> 19 <i>67</i> Month Day Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/17/07</i>	9. AGE (in years last birthday) <i>59</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i>	
13. FATHER'S NAME <i>Carl Helwig</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-30-1700</i>		17. INFORMANT <i>Husband</i> Address <i>Same as Item 2.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Coronary sclerosis</i> DUE TO (c) <i>Arteriosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> <i>5 yrs.</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <i>Home</i> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 1940</i> to <i>Jan 30, 1967</i> , that (I) (we) last saw the deceased alive on <i>Dec 15, 1966</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>E.H. Aschenbach</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1-30-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>E.H. Aschenbach</i>		22d. ADDRESS <i>1841 Col. Rd. N.W.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-1-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Prince George County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>			25a. REC'D BY REGISTRAR <i>FEB 2 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

Mr. Ball notified and
approved. *E. Marshall*

00996

CERTIFICATE OF DEATH

00995

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faithersburg</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>104 - Brooks Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vinson</u> Middle <u>F.</u> Last <u>Mullican</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/1900</u>	9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vinson M. Mullican</u>				14. MOTHER'S MAIDEN NAME <u>Annie McCarthy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>210 577-10-1391</u>		17. INFORMANT <u>Virgie Mullican</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Metastatic to Lung</u> DUE TO (b) <u>Carcinoma, Urinary bladder, Melanoma finger</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 4, 1966</u> to <u>Jan. 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> 19 <u>67</u> , and that death occurred at <u>3:40</u> M. from causes and on the date stated above.							
22a. SIGNATURE <u>John D. Mayloth</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Mayloth</u>				22d. ADDRESS <u>Rockville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring - monty md</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>				ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1990

00997

CERTIFICATE OF DEATH

00996

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4730 Southern Ave S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shirley B. Mundaray</u>				4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3 1932</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Albert Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Alice A. Hall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-44 2103</u>		17. INFORMANT <u>Alice Buckett</u> Address <u>4274 Capital St. Wash. D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>003.1</u> DUE TO <u>Pleural effusion and pulmonary edema.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO <u>Viral myocarditis</u> (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/4/67</u> , 19 <u>67</u> , to <u>1/12/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/12/67</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Richard Myers</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD MYERS</u>				22d. ADDRESS <u>8512 Old Georgetown Rd. Bldg.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Ceme.</u>		23d. LOCATION (City or Town) (County) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>John T. Stewart</u>				25a. REC'D BY REGISTRAR <u>N.E.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Stewart Funeral Home-4001 Benning Rd.,				DATE <u>JAN 16 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00998						00997					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Montgomery			CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town)			D.C.			Washington		
c. LENGTH OF STAY IN b.			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
17 Months			Brookgreen Foundation			13316 Georgia Ave.			15-1		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First Middle Last			Month Day Year			F W			W		
MARY MARTHA MUNSON			JAN 11 1967								
5. SEX			6. COLOR OR RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
									4/9/88		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housewife						Washington, D.C.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
Paul Bickler			Elizabeth Schatz			No			21348152		
17. INFORMANT			Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH		
Mrs Emory T Bachman			South Hill Coatesville Penna.			PULMONARY CONGESTION			TERMINAL		
						MYOCARDIAL ISCHEMIA					
						ARTERIOSCLEROTIC HEART DISEASE			YRS.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
HYPOSTATIC PNEUMONIA : ORGANIC BRAIN SYNDROME											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from 8/30, 1965 to 1/11, 1967 that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			22a. SIGNATURE			22b. DATE SIGNED					
Wond L. Lewis			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS								
Dr. Donald Lewis M.D.			Alney, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
BURIAL			1/14/67			ROSE HILL CEMETERY			HAGERSTOWN Md.		
24. FUNERAL DIRECTOR'S SIGNATURE			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Charles R. Rouse			DATE JAN 16 1967			f Charles Judge					

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UNITED STATES OF AMERICA

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CERTIFICATE OF DEATH

00998

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY 48.3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 170 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N. I. H.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Shafter Biby Newton		4. DATE OF DEATH Month Day Year January 17 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 November 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Filling Station	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Torance Newton		14. MOTHER'S MAIDEN NAME Fannie Eldridge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 261-10-6197	
17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cryptococcal meningoencephalitis DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 2-3 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 July , 19 66 , to 17 Jan. , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 Jan. , 19 67 , and that death occurred at 11:00 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Rob Roy MacGregor		22b. DATE SIGNED January 18, 1967	
22c. PHYSICIAN'S NAME (Type) Rob Roy MacGregor, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL (CREMATION, REMOVAL) (Specify) Rem. - Burial	23b. DATE THEREOF 1/19/67	23c. NAME OF CEMETERY OR CREMATORY Mellville Cemetery	23d. LOCATION (City or Town) (County) (State) Panama City, Florida
24. FUNERAL DIRECTOR W. H. Murphy		25a. REC'D BY REGISTRAR JAN 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2420

2230

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01000

00999

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp.</u>		d. STREET ADDRESS <u>240 Randolph Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>John N M W Nichols</u>		4. DATE OF DEATH <u>1-29-1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-08</u>
9. AGE (In years, lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>29</u> Days <u>15</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Market</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Nicolou plous</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Duonis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wife, Mrs Sarah Nichols</u>	
17. INFORMANT <u>Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemorrhage due to</u> <u>451x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured abdominal aortic aneurysm</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 1st 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>Simmons Bros.-1661-Good Hope Rd SE Wash DC</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>1/29/1967</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01001

CERTIFICATE OF DEATH

01000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>9709 Saxony Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9709 Saxony Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u>		First <u>Mary</u> Middle <u>Louise</u> Last <u>Niehues</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>19 67</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1873</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dayton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Neff</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Isabel Niehues</u>		Address <u>9709 Saxony Road</u> <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, cerebral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>332X</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>11/17/66</u> , 19 <u> </u> , to <u>1/15/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>12/20/66</u> , 19 <u> </u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
22e. SIGNATURE <u>A. W. Smith</u>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. W. SMITH</u>		22d. ADDRESS <u>13018 GEORGIA AVE WHEATON, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>St. 1-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington, D. C.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u>		ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

Cleaned by Medical Examiner
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01002					01001									
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE									
Montgomery					Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
Damascus					Damascus									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM?									
26909 Howard Chapel Dr.					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last Louie W. Noe					Month Day Year Jan. 11 1967									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec. 31, 1892		74 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Farmer						Indiana		USA						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Milton Noe					Louella Doughty									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address									
Yes			W.W. # 1		Mrs Mary C. Noe, Item 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>18 years</i>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>10/7</i> , 196 <i>0</i> , to <i>1/11</i> , 196 <i>7</i> , that (I) was last saw the deceased alive on <i>1/5</i> , 196 <i>7</i> , and that death occurred at <i>5P</i> M, from the causes and on the date stated above.														
22a. SIGNATURE <i>James P. Kerr</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/12/67						
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.					22d. ADDRESS Damascus, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
Burial			Jan. 13, 1967		Pine Grove		Mt. Airy, Md.							
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.					25a. REC'D BY REGISTRAR DATE JAN 16 1967					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

10010

10010

20000 Howard Street

20000 Howard Street

Dec. 2, 1950

Dec. 2, 1950

Deborah Douglas

Deborah Douglas

Mr. Mary O. Wood, 11th St.

Mr. Mary O. Wood, 11th St.

Memphis, Tenn.

Memphis, Tenn.

Mr. Mary O. Wood

Mr. Mary O. Wood

Mr. Mary O. Wood

Mr. Mary O. Wood

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01003

CERTIFICATE OF DEATH

01002

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs, Md.</i>		c. LENGTH OF STAY IN 1b <i>1 hr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jane</i> Middle <i>P.</i> Last <i>Novo</i>		4. DATE OF DEATH Month <i>1</i> Day <i>10</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/3/20</i>
9. AGE (In years lost birthday) yrs. <i>46</i>		10. IF UNDER 1 YEAR Months <i>10</i> Days <i>19</i> Hours <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Buffalo, New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes USA</i>	
13. FATHER'S NAME <i>Morris Rantz</i>		14. MOTHER'S MAIDEN NAME <i>Southern Peterson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Ramon Novo</i>		Address <i>603 Goldsborough Dr.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>331X Spontaneous subarachnoid Hemorrhage 2 hours</i> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3:30 PM 10/1/67</i> to <i>5:15 PM 10/1/67</i> , that (I) (we) last saw the deceased alive on <i>10/1/67</i> , and that death occurred at <i>5:15 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. Macor</i>		22b. DATE SIGNED <i>1-11-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT C. MACON</i>		22d. ADDRESS <i>809 Viers Mill Rd, Rockville</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-13-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Bethesda H.O.</i>		25a. REC'D BY REGISTRAR <i>J. Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		DATE <i>JAN 18 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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39920

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01004

01003

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARY HOSP				d. STREET ADDRESS 17 Canterbury Square		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUE First		Middle LEWIS		Last OBRIAN		4. DATE OF DEATH Month 1 Day 22 Year 1967	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-35 31 Yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec		10b. KIND OF BUSINESS OR INDUSTRY Kellogg Ind.		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Bowker Lewis				14. MOTHER'S MAIDEN NAME Dorothea Leftwich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT mother - Mrs Dorothea Lewis Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Multiple, Extreme, Internal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Injuries and fractures DUE TO (c) with Exsanguination						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased injured when auto (she was a passenger) struck light pole on Rte 495					
20c. TIME OF INJURY Month, Day, Year 1-22-67 Hour 4 a.m. P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Silver Spring (County) Montgom. (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Peap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED JAN. 22, 1967	
EXAMINER'S NAME (Type) BELDEN R. PEAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-25-67		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) Falls Church Fairfax VA.	
24. FUNERAL DIRECTOR LIVES FUNERAL HOME BY E. Ryan Jr. ADDRESS 2849 Wilson Blvd. Arlington, VA. 22201				25a. REC'D BY REGISTRAR JAN 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

01003

0001

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01005				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				01004			
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u> <u>15.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6432 Wisconsin Rd.</u>						d. STREET ADDRESS <u>6432 Wisconsin Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Ruth</u> Last <u>O'Connell</u>						4. DATE OF DEATH Month <u>Jan</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>Fe-</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23, 1918</u> <u>64</u> yrs.		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MASSACHUSETTS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick J. Maloney</u>						14. MOTHER'S MAIDEN NAME <u>Mary Louise Kelleher</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>JAMES A. MALONEY (BRO.)</u>				Address <u>MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>322.0</u> IMMEDIATE CAUSE (a) <u>ALCOHOLIC</u> <u>Alcohol intoxication Acute</u> DUE TO (b) <u>Chronic alcoholism</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>0 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Drank too much alcohol</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drank too much alcohol</u>							
20c. TIME OF INJURY Month, Day, Year <u>2:00</u> <u>Jan 2</u> <u>1967</u> <u>p.m.</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Glen Echo</u> <u>Montg.</u> <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John G. Bell</u> M.D.						22. DATE SIGNED <u>1/3/67</u>					
EXAMINER'S NAME (Type) <u>John G. Bell</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>1/3/67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>Jan. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>				23d. LOCATION (City or Town) (County) (State) <u>WHEATON, MONTGOMERY, MD.</u>	
24. FUNERAL DIRECTOR <u>H. DON. DeCol</u> ADDRESS <u>2222 Wisconsin Ave N.W. Wash.</u>						25a. REC'D BY REGISTRAR <u>JAN 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2010

2020

01006

CERTIFICATE OF DEATH

01005

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN 1b 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle C. Last OFFUTT		4. DATE OF DEATH Month Jan. Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Feb. 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Offutt		14. MOTHER'S MAIDEN NAME Annie R. Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-30-2267A	
17. INFORMANT Lucile C. Offutt - Item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 ARTERIOSCLEROSIS, GENL. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheo-Bronchitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-25-19 , to 1-10-67 , that (I) (we) last saw the deceased alive on 12-12-1966 , and that death occurred at 8:45 p.m. from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED 1-11-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/13/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION (City or Town) (County) (State) Barnesville, Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike		25a. REC'D BY REGISTRAR JAN 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01002

01000

120

FOR STATE
HEALTH DEPT.

01007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01006

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MICHIGAN b. COUNTY WAYNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GROSSE POINTE WOODS 59.3	
c. LENGTH OF STAY IN 1b 1 1/2 DAY		d. STREET ADDRESS 1086 BRY'S DRIVE NORTH	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Walter OKARSKI		4. DATE OF DEATH Month Day Year JANUARY 27 19 67	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JUNE 1942
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.N.A.		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RALPH WALTER OKARSKI		14. MOTHER'S MAIDEN NAME REGINA BAGINSKI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1965-67		16. SOCIAL SECURITY NO. 366-42-4693	
17. INFORMANT RALPH W. OKARSKI, GROSSE POINTE WOODS, MICH.		18. ADDRESS 1086 BRY'S DRIVE NORTH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema + Pulmonary Edema. 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) When diving in river under instructions of Navy Diving school, panicked and pulled out air hose.			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr.
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) as above in Part II	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10:40 p.m. Jan 26 19 67	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River Anacosta	20f. (City or town) (County) (State) Washington D.C.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/30/67	
23c. NAME OF CEMETERY OR CREMATORY MT OLIVET		23d. LOCATION (City or Town) (County) (State) DETROIT WAYNE MICHIGAN	
24. FUNERAL DIRECTOR W.W. CHAMBERS, 1400 CHAPIN ST, NW, WASH., D.C.		25a. REC'D BY REGISTRAR DATE FEB 2 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01007

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1951

UNITED STATES DEPT. OF JUSTICE

01008

CERTIFICATE OF DEATH

01007

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE CALIFORNIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)			c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inglewood 43.3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 3726 Century Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances Anastasia OKUNEWICK				4. DATE OF DEATH Month Day Year January 11 19 67			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1906		9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner business		10b. KIND OF BUSINESS OR INDUSTRY Trailer park		11. BIRTHPLACE (County & State, or foreign country) Merrill, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Lapinski				14. MOTHER'S MAIDEN NAME Rosalie Retka			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 545 40 7905		17. INFORMANT ville, Md. Address James OKunewick, 14108 Arctic Ave., Rock-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Obstruction large bowel DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Adenocarcinoma, large bowel DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 28 , 19 66 , to Jan. 11 , 19 67 , that (X) (we) last saw the deceased alive on Jan. 11 , 19 67 , and that death occurred on 830A M, from causes on and on the date stated above.							
22a. SIGNATURE <i>R. J. Kinney</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 12, 1967	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY, LCDR MC USN				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/67		23c. NAME OF CEMETERY OR CREMATORY Fort Rosecrans		23d. LOCATION (City or Town) (County) (State) San Diego, California	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, 1331 East Montgomery Ave., Rockville, Md.				25. REC'D BY REGISTRAR JAN 16 1967 DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1992

3052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G384 1/18/67 mh

01009

CERTIFICATE OF DEATH

01008

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington DC b. COUNTY Washington DC		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 13 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington DC		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US Naval Hospital			d. STREET ADDRESS 1650 Harvard Street N.W.		
3. NAME OF DECEASED (Type or print) First Basilia Middle Lopez Last Olalla			4. DATE OF DEATH Month Jan. Day 7 Year 19 67		
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 23, 1904		9. AGE (In years last birthday) yrs. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE (County & State, or foreign country) Spain	
13. FATHER'S NAME Clemente Lopez			14. MOTHER'S MAIDEN NAME Juana Olalla		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Maria Criado 1650 Harvard St., Washington, DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST WITH WIDESPREAD METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec. 26, 19 66 to Jan. 7, 19 67 , that (I) (we) last saw the deceased alive on Jan. 7, 19 67 , and that death occurred at 11:55 P.M. from causes on and on the date stated above.					
22a. SIGNATURE R. J. Kimney M.D.			22b. DATE SIGNED 8 January 67		
22c. PHYSICIAN'S NAME (Type) R. J. Kimney M.D.			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 1/11/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Hanes Funeral Home 14th and Harvard St.			25a. REC'D BY REGISTRAR JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

James Earl Ray, Jr.

to not

D. D. Jones

U. S. Navy Hospital, Bethesda, Md.

7.687,

14

22.5-6

7. 10. 19

73

CERTIFICATE OF DEATH

01009

01010

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 11.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.			d. STREET ADDRESS 6623 Western Ave., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Margaret EMMETT O'NEILL			4. DATE OF DEATH Month Day Year January 2 1967		
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1912	9. AGE (In years lost birthday) 54/56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse-Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Steelton, Pa.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Thomas Daily		
14. MOTHER'S MAIDEN NAME Elizabeth McCoulagh			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Charles J. O'Neill 6623 Western Ave., N.W. Washington, D. C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 583X HEPATIC FAILURE AND RENAL FAILURE IMMEDIATE CAUSE (a) HEPATIC FAILURE AND RENAL FAILURE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 20 December 1966 , to 2 January 1967 , that (I) (we) last saw the deceased alive on 2 January 1967 , and that death occurred at 3:15 PM , from causes and on the date stated above.					
22a. SIGNATURE Peter T. Kirchner			22b. DATE SIGNED 2 Jan. 1967		
22c. PHYSICIAN'S NAME (Type) Peter T. Kirchner			22d. ADDRESS Naval Hospital, Bethesda, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City or Town) (County) (State) Harrisburg Dauphin, Pa.		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home			25a. REC'D BY REGISTRAR DATE JAN 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	
7557 Wisconsin Ave., Bethesda, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01010

Washington, D.C.

Washington

Washington

12 days

January (1941)

2000 Washington Ave., N.W.

Naval Hospital, Bethesda, Md.

Private

Medical Records

11-11-41

Group

Johnson, Pa.

Johnston, Pa.

Discharge

Discharge

2000 Washington Ave., N.W.

Johnston, Pa.

Johnston, Pa.

Johnston, Pa.

2000 Washington Ave., N.W.

Johnston, Pa.

Naval Hospital, Bethesda, Md.

Naval Hospital, Bethesda, Md.

01000

Johnston, Pa.

Johnston, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 010101										01010									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 1/2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Warrenton</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>83.3</u> d. STREET ADDRESS <u>83.3</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTHA Theresa O'Reilly</u>					4. DATE OF DEATH Month Day Year <u>21 12 1967</u>					5. SEX <u>F</u>									
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1878</u>		9. AGE (In years last birthday) <u>89</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY					13. FATHER'S NAME <u>Robert T. O'Reilly</u>									
14. MOTHER'S MAIDEN NAME <u>MARGARET HARTY</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO.									
17. INFORMANT <u>Address</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) <u>7 YRS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 MC</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 15, 1966</u> to <u>JAN 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>JAN 6, 1967</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>DR LEO F. DOMINOW</u> M.D.										22b. DATE SIGNED <u>1/6/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>DR LEO F. DOMINOW</u> M.D.										22d. ADDRESS <u>8218 WISL AVE Bethesda MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					23b. DATE THEREOF <u>2-9-67</u>					23c. NAME OF CEMETERY OR CREMATORY <u>WARRENTON CEMETERY</u>									
23d. LOCATION (City, town or county) (State) <u>Warrenton, Virginia</u>					24. FUNERAL DIRECTOR <u>Joseph GAWLERS SONS</u>					25a. REC'D BY REGISTRAR <u>5130 WISL AVE N.W. WASH. D.C.</u>									
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					DATE <u>JAN 12 1967</u>														

01010

01010

CERTIFICATE OF DEATH

01012

01011

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>807 Stonestreet Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>807 Stonestreet Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEWIS HENSON OWENS</u>				4. DATE OF DEATH <u>JAN. 12 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1898</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Solomon Owens</u>				14. MOTHER'S MAIDEN NAME <u>Sally Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-44-2758</u>			
17. INFORMANT <u>Lenora Owens, Wife</u> Address <u>807 Stonestreet Ave. Rockville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Massive Somatic Obesity, Diarrhea, Foot OPERATION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1955</u> to <u>1-12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-6-1966</u> and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Clive E. Jackson</u> M.D.				22b. DATE SIGNED <u>1-13-67</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>202 Martin Lay, Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>Jan. 17, 1967</u>		<u>Lincoln Park</u>		<u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u> 25b. REGISTRAR'S SIGNATURE			
DATE <u>JAN 17 1967</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11010

2000-10-10

01013

CERTIFICATE OF DEATH

01012

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3111 CUMMINGS LA. CHEVY CH. MD</u>		d. STREET ADDRESS <u>3111 Cummings Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>FLOY</u> Last <u>LEE PALMER</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/98</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>LUTHER McCAULEY</u>		14. MOTHER'S MAIDEN NAME <u>LOULA PARKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>MRS. SHIRLEY JONES</u>		Address <u>CHEVY CH. MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Probable Cardiovascular Accident (Anno Domini)</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>15 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>1/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 15</u> , 19 <u>66</u> , and that death occurred at <u>5 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin P. Parker</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN P. PARKER</u>		22d. ADDRESS <u>2015 R St. NW - Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEO. CO., MD</u>
24. FUNERAL DIRECTOR <u>JOSEPH GANLER SONS</u>		25a. REC'D BY REGISTRAR <u>5130 WISC. AVE.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 26 1967</u>	

01010

CERTIFICATE OF DEATH

01010

11

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	

01014

CERTIFICATE OF DEATH

01013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland			c. LENGTH OF STAY IN lb Holy Cross Hospital		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital, Silver Spring, Md.			d. STREET ADDRESS 335 Howard Avenue		
3. NAME OF DECEASED (Type or print) Marion E. Parsons			4. DATE OF DEATH Month January Day 11 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/1922		9. AGE (In years lost birthday) yrs. 44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Tatium Davis			14. MOTHER'S MAIDEN NAME Harriett Mundy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 084-20-1177	17. INFORMANT Address David R. Parsons-husband--same item #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) MELASTATIC CARCINOMA DUE TO (b) PULMONARY CARCINOMA DUE TO (c) PULMONARY CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 6-8 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 19 65 , to 19 67 , that (I) (we) last saw the deceased alive on 19 67 , and that death occurred at 6:45 M, from causes and on the date stated above.					
22a. SIGNATURE D.R. Bucy		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-12-67	
22c. PHYSICIAN'S NAME (Type) D.C. Bucy		22d. ADDRESS 809 Veirs M.H. Rd Rockville Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/16/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rockville Pike		25a. REC'D BY REGISTRAR 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

61019

61019

100-100000-100000

FOR STATE
HEALTH DEPT.

01015

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01014

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10019 Kinross Rd</u>				d. STREET ADDRESS <u>10019 Kinross Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Thomas Henry Payne</u>				4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8, 1912</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brunswick Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Appleton Payne</u>				14. MOTHER'S MAIDEN NAME <u>Emma Kirby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-2177</u>		17. INFORMANT Address <u>Emma V. Payne--wife--same item # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute hemorrhagic pancreatic necrosis</u> <u>5870</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <u>1/29/1967</u>
ACTUAL SIGNATURE <u>Belden R. Reap</u>		EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u>		
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>13 Rock. Pike</u>		25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Frank Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01016

CERTIFICATE OF DEATH

01015

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Alabama b. COUNTY Lee		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 12½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Opelika 40-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home			d. STREET ADDRESS 211 N. 11th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Adelaide Middle Tomlinson Last Pearson			4. DATE OF DEATH Month 1 Day 11 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 12, 1886 80yrs.	9. AGE (In years lost birthday) 80yrs.	IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) LaGrange, Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jabez Tomlinson		
14. MOTHER'S MAIDEN NAME (Unknown) Bull			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		
16. SOCIAL SECURITY NO. 417-145799		17. INFORMANT Ernest O. Pearson, Jr. Address 2907 Fortsythe Ave. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 491X IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Cereiosclerosis					INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/24/65 , 19 to 1/11/67 , 19, that (I) (we) last saw the deceased alive on 1/10/67 , 19, and that death occurred at 135P M, from causes and on the date stated above					
22a. SIGNATURE Henry C. Scribbs		22b. DATE SIGNED 1/11/67		22c. PHYSICIAN'S NAME (Type) HENRY C. SCRIBBS M.D.	
22d. ADDRESS 5413 Cedar Lane Bethesda Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Rosemere Cemetery	
23d. LOCATION (City or Town) Opelika, Alabama					
24. FUNERAL DIRECTOR Glen Carter Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR JAN 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

01017

CERTIFICATE OF DEATH

01016

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>12816 PARKLAND Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>SEYMOUR</u> Middle <u>PEPPERMAN</u> Last <u>PEPPERMAN</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/18</u>		9. AGE (In years last birthday) <u>48</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner-Service Stations</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Owner-Service Stations</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Julius Pepperman</u>			
14. MOTHER'S MAIDEN NAME <u>Rose Libby</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Mrs. Ida Pepperman, 12816 Pkland Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>153.8</u> IMMEDIATE CAUSE (a) <u>Mitastatic Carcinoma</u> DUE TO (b) <u>Adenocarcinoma of Colon</u> DUE TO (c) <u>Pulmonary Embolism & Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>6 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 14, 1966</u> , to <u>Jan 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 14, 1967</u> , and that death occurred at <u>2:40 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>Jan 15, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. HIG</u>				22d. ADDRESS <u>8641 Colomeda Rd, Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Ch., Va.</u>	
24. FUNERAL DIRECTOR <u>B Danyansky & Son</u>				ADDRESS <u>3501-14th St N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>JAN 18 1967</u>			

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01018

CERTIFICATE OF DEATH

01017

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 8 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 6004 Princeton Ave.	
3. NAME OF DECEASED (Type or print) ALICE L. PERRY		4. DATE OF DEATH Month Jan. Day 3, Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1889
9. AGE (In years lost birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min. 15.1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rufus A. Rager		14. MOTHER'S MAIDEN NAME Susan Loretta Boyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Sister		Address Mr. W. J. Middleton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral Vascular Accident (Thrombosis) DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 and 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Free of unknown origin			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (State nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-24-1966 , to 1-2-1967 , that (I) (we) saw the deceased alive on 1-2-1967 , and that death occurred at 6:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Irwin H. Ardani		22b. DATE SIGNED 1-3-67	
22c. PHYSICIAN'S NAME (Type) IRWIN H. ARDANI, M.D.		22d. ADDRESS 1712 - I - St. N.W. WASH, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-5-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JAN 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

81010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01013					01018				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			d. STREET ADDRESS <u>13110 Superior Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Evelene</u> Middle <u>D.</u> Last <u>Pettit</u>					4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mch 9, 1918</u>		9. AGE (in years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>15</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clem Denney</u>					14. MOTHER'S MAIDEN NAME <u>Mary Roberts</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>417-20-0158</u>		17. INFORMANT <u>William Pettit - husband - same item # 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF THE CERVIX</u> <u>171X</u> DUE TO (b) <u>(ADENOCARCINOMA)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>14 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 24 1965</u> to <u>1/24</u> , 1967, that (I) (we) last saw the deceased alive on <u>1/24</u> , 1967, and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard A. Pollen</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard Pollen</u>					22d. ADDRESS <u>10511 Summit Ave., Kensington, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>		
24. FUNERAL DIRECTOR <u>Tyson Wheeler 1331 Rock. Pike, Rockville, Md.</u>					25a. REC'D BY REGISTRAR <u>JAN 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

01010

01010

STATE OF NEW YORK
IN SENATE
January 1, 1901
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS.
1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01020

01019

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, DC b. COUNTY 473	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC	
c. LENGTH OF STAY IN lb 102 Days		d. STREET ADDRESS 3646 13th Street NW	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luther Middle Abner Last Pickens		4. DATE OF DEATH Month January Day 7 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1895
9. AGE (In years lost birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
11. BIRTHPLACE (County & State, or foreign country) Bloomfield, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry T. Pickens		14. MOTHER'S MAIDEN NAME Rhoda Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 1915-1919 (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579 01 4504	
17. INFORMANT Naval Hospital and Veteran's Administration		Address records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 180X IMMEDIATE CAUSE (a) Carcinoma Left kidney - recurrent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with widespread metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 28 , 19 66 , to Jan. 7 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 7 1967 , and that death occurred at 6:00A M, from causes and on the date stated above.			
22a. SIGNATURE F. J. Frensilli		22b. DATE SIGNED 10 Jan. 1967	
22c. PHYSICIAN'S NAME (Type) F. J. FRENSILLI, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin Street, N. W. Washington, D. C.		25a. REC'D BY REGISTRAR JAN 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

01019

REPORT OF CLAIM

01020

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

January 1, 1961

January 1, 1961

January 1, 1961

January 1, 1961

January 1, 1961

January 1, 1961

USA

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January 1, 1961

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Washington, D.C.

January 1, 1961

January 1, 1961

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1-66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G385 1/27/67 mh

01021

CERTIFICATE OF DEATH

01020

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>7520 Radnor Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>N.</u> Last <u>Pilgren</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7-1980</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Works</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Marshalltown, Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter August Pilgren</u>				14. MOTHER'S MAIDEN NAME <u>Emma Nox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-10-1087</u>		17. INFORMANT <u>wife</u> Address <u>Same as Item 2.</u> <u>Yolande B. Pilgren</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Occlusion.</u> DUE TO (c) <u>Cardio Vascular Disease.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days.</u> <u>years.</u>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> , 19 <u>67</u> , to <u>1/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>John G. Ball</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John G. Ball</u>				22d. ADDRESS <u>7936 Georgetown Rd Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-21-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>JAN 23 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01080

01080

STATE OF TEXAS

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01022					CERTIFICATE OF DEATH					01021				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fairland Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47.3 d. STREET ADDRESS 2101 16th Street N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First LILLIAN Middle M. Last POLLOCK					4. DATE OF DEATH Month 1 Day 23 Year 1967									
5. SEX Female					6. COLOR OR RACE White					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH 6/3/81					9. AGE (In years last birthday) 85 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gov. employee					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Lewiston, Ill.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME John Pollock					14. MOTHER'S MAIDEN NAME Jennie Grimes				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or dates of service)					17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 331X DUE TO (b) Bronchopneumonia DUE TO (c) Possible C. V. A.										INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs. 7-10 days 7-10 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mastectomy rt side apparently due to Ca. Squamous carcinoma										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 2-29 , 19 64 , to 1-23 , 19 67 , that (II) (we) last saw the deceased alive on 1-18 , 19 67 , and that death occurred at 3:40 M, from the causes and on the date stated above.										22a. SIGNATURE John R. Spencer 22b. DATE SIGNED 1-23-67 22c. PHYSICIAN'S NAME (Type) John R. Spencer M.D. 22d. ADDRESS 15444 Columbia PK. Burtonsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation										23b. DATE THEREOF 1/26/67				
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory										23d. LOCATION (City, town or county) (State) Prince Georges County, Md.				
24. FUNERAL DIRECTOR S.H. Hines Co										ADDRESS Wash. D. C.				
25a. REC'D BY REGISTRAR JAN 26 1967										25b. REGISTRAR'S SIGNATURE Charles Judge				

50

01023

CERTIFICATE OF DEATH

01022

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>				d. STREET ADDRESS <u>127 S. Van Buren St.</u>			
3. NAME OF DECEASED (Type or print) <u>Blanche C. Pontius</u>				4. DATE OF DEATH <u>Jan 17 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/1888</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Emma Truver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry E. Pontius, son same item #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>153.0</u> IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Cecum</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>64</u> to <u>Jan 17, 1967</u> , that (I) (we) saw the deceased alive on <u>Jan 17, 1967</u> , and that death occurred at <u>5:11 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Herman C. Maganzini</u> M.D.				22b. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>		22c. DATE SIGNED <u>Jan 17, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cuyahoga Falls</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR <u>1551 Rock. Pike Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01085

RECEIVED BY DEATH

01085

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "BY DEATH" are visible.]

01024

CERTIFICATE OF DEATH

01023

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day 10 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>917 Burnt Crest Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Boy</u> Middle <u>Pool</u> Last <u>Pool</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 31, 1966</u>		9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u>45</u> Min.	IF UNDER 24 HRS. Hours <u>45</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery - Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CLIFF L. POOL</u>				14. MOTHER'S MAIDEN NAME <u>Compton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>762.0</u> IMMEDIATE CAUSE (a) <u>Atelectasis Congenital</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Congenital anomalies, Multiple</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/31/66</u> , 19 <u>66</u> , to <u>1/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/1</u> , 19 <u>67</u> , and that death occurred at <u>11:25</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>Vito R. Jaffe, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAFFE, VITO R. M.D.</u>				22d. ADDRESS <u>5079 Brady Rd. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City or Town) (County) (State) <u>Bethesda - Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>MRS Amelia Carter, Administrator</u>				25a. REC'D BY REGISTRAR DATE <u>AN 9</u> 19 <u>67</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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Walter

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